STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/6/15 through 10/8/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 190 certified bed facility was 180 at the time of the survey. The survey sample consisted of 30 current resident reviews (Residents #1 through #25, Resident #30 and Residents #34 to #37) and seven closed record reviews (Residents #26 to #29 and Residents #31 to #33).	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason A. Mumo — TITLE: Administrator — (X6) DATE: 10/30/15

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or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to notify the RP (responsible party) and physician regarding changes in treatment and care for three of 37 residents in the survey sample, Residents #16, #19 and #13.

1. On 7/21/15 the psychiatrist wrote an order to discontinue an antipsychotic for Resident #16 based on a pharmacy recommendation. Resident #16's primary care physician and RP (responsible party) were not notified of this change in medication therapy.

2. On 8/10/15 the nurse practitioner ordered an additional dose of Seroquel * (an antipsychotic medication used to treat schizophrenia, bipolar disorder and psychosis), for Resident #19. Resident #19's RP was not notified of this medication change.

3. Facility staff failed to notify the physician of Resident # 13's refusal of an x-ray of her right hip.

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The findings include:

1. On 7/21/15 the psychiatrist wrote an order to discontinue an antipsychotic for Resident #16 based on a pharmacy recommendation. Resident #16's primary care physician and RP (responsible party) were not notified of this change in medication therapy.
Resident #16 was admitted to the facility on 3/31/08 with diagnoses that included, but were not limited to: AMS (altered mental status), dementia, anxiety, hypertension, insomnia, diverticulitis (An inflammation or infection in one or more small pouches in the digestive tract), behavior disturbance, hypothyroidism (decreased thyroid function) and hyperlipidemia (increased lipids in the blood stream).
The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 8/13/15. Resident # 16 was coded as scoring three out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #16's clinical record revealed a pharmacy consultation report dated 7/13/15 recommending that a GDR (gradual dose reduction) be considered for Seroquel*. The following response, in part, was written on the recommendation; "Physician's Response: I accept the recommendation above, please implement as written. D/C (discontinue) Seroquel 25 mg (milligrams) 1/2 po (by mouth) 12.5 mg Qhs (at bedtime)." The order was signed by the psychiatrist on 7/21/15.

Further review of Resident #16's clinical record

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did not reveal any documentation to evidence that Resident #16's primary physician and RP were notified of the new order.

On 10/7/15 at 5:10 p.m., an interview was conducted with LPN (licensed practical nurse) #10 regarding the process followed when an order to reduce an antipsychotic medication is received. LPN #10 stated, "We follow the normal process for new medication orders, send them to the pharmacy and put on the MAR (medication administration record). Then we call the MD (medical doctor) and the RP."

On 10/8/15 at 10:35 a.m. an interview was conducted with LPN #15. LPN #15 regarding the process followed when a new medication order is received. LPN #15 stated, "I transcribe the order, contact the RP and make a note in the nurse's notes stating that the RP was notified of the changes."

On 10/8/15 at approximately 11:30 a.m. ASM (administrative staff member) #1, the administrator, was made aware of the above findings. ASM #1 was asked to provide a facility policy regarding notification.

On 10/8/19 at 3:00 p.m. an interview was conducted with LPN #9, the unit manager. LPN #9 was asked when the primary physician and/or RP should be notified. LPN #9 responded, "Any time there is a change in the resident's condition/status. Any time there is a new order." LPN #9 was asked what should be done when a resident's antipsychotic medication was changed. LPN #9 responded, "The RP and primary physician should be called and notified, a note should be put in the progress notes." LPN #9

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was asked whether or not Resident #16's physician or RP were notified when Resident #16's Seroquel was discontinued. LPN #9 reviewed Resident #16's clinical record and stated, "I do not see any documentation."

No further information was provided prior to the end of survey.

* This information was obtained from the following website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/

2. On 8/10/15 the nurse practitioner ordered an additional dose of Seroquel* (an antipsychotic medication used to treat schizophrenia, bipolar disorder and psychosis), for Resident #19. Resident #19's RP was not notified of this medication change.

Resident #19 was admitted to the facility on 4/30/15 with a readmission on 6/18/15, with diagnoses that included, but were not limited to: epilepsy (a form of seizures), anxiety, hypertension, depression, pain and ulcer. The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 9/8/15. Resident # 19 was coded as scoring two out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #19's clinical record revealed the following telephone order received

F 157 (D):

1. Resident #16 and #19, the Responsible Party and the Physician were notified of antipsychotic medication change. Resident #13, the Responsible Party and the Physician were made aware of refusal of right hip x-ray.
2. A review of residents receiving antipsychotics within the last 30 days will be conducted to ensure proper notification to the physician and the RP. A review of residents who have had x-rays in the last 30 days will be conducted to ensure that refusals have appropriate notification to the physician and RP.

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F 157	Continued From page 5	F 157	3. The Assistant Director of Clinical Services/Designee will check new orders and progress notes during morning meeting to ensure that the RP and Physician have been notified. The Staff Development Coordinator/ Designee has educated Licensed Staff on the procedure of RP/Physician notification of antipsychotic medication changes. The Staff Development Coordinator/Designee has educated Licensed Staff on notification regarding x-ray refusals to RP/Physician. The DCS/Designee will perform random weekly reviews for (5) residents per week for (3) months to ensure that the RP/Physician were made aware of antipsychotic medication changes. Weekly reviews will be conducted by the DCS/Designee for (5) residents per week for (3) months to ensure that the RP/Physician have been made aware of refusals of x-rays.	

by nursing on 8/10/15 documenting, in part, the following documentation: "Date/Time 8/10/15. Medication: Seroquel 12.5 mg (milligram) PO (by mouth) at noon daily. Indication - Dx (diagnosis) Psychosis, NOS (new onset symptoms)." The order was signed by the nurse practitioner on 8/10/15.

Further review of Resident #19's clinical record did not reveal any documentation to evidence that Resident #19's RP was notified of the new medication order.

On 10/7/15 at 5:10 an interview was conducted with LPN (licensed practical nurse) #10, regarding the process followed for new medication orders. LPN #10 stated, "We follow the normal process for new medication orders, send them to the pharmacy and put on the MAR (medication administration record). Then we call the MD (medical doctor) and the RP."

On 10/8/15 at 10:35 a.m. an interview was conducted with LPN #15. LPN #15 was asked to describe her process when she received a new medication order. LPN #15 stated, "I transcribe the order, contact the RP and make a note in the nurse's notes stating that the RP was notified of the changes."

On 10/8/15 at approximately 11:30 a.m. ASM (administrative staff member) #1, the administrator, was made aware of the above findings. ASM #1 was asked to provide a facility policy regarding notification.

On 10/8/19 at 3:00 p.m. an interview was conducted with LPN #9, the unit manager. LPN #9 was asked when the primary physician and/or

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RP should be notified. LPN #9 responded, "Any time there is a change in the resident's condition/status. Any time there is a new order." LPN #9 was asked what should be done when a resident's antipsychotic medication was changed. LPN #9 responded, "The RP and primary physician should be called and notified, a note should be put in the progress notes." LPN #9 was asked whether or not Resident #19's RP was notified when the nurse practitioner added a dose of Seroquel. LPN #9 reviewed Resident #19's clinical record and stated, "I do not see any documentation."

No further information was provided prior to the end of survey.

* This information was obtained from the following website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/

3. Facility staff failed to notify the physician of Resident # 13's refusal of an x-ray of her right hip.

Resident # 13 was admitted to the facility on 7/13/15 with diagnoses of but not limited to: history of chronic obstructive pulmonary disease (disease that makes it difficult to breath that can lead to shortness of breath), hypertension (high blood pressure), hemiparesis (weakness on one side of the body), anxiety (a strong, irrational fear of something that poses little or no real danger), depression, schizophrenia (a serious brain illness), muscle weakness, history of fall, obsessive compulsive disorder (a type of anxiety disorder) and dysphagia (a swallowing disorder).

4. Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. Revisions will be recommended by the committee as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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The most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/20/15 coded Resident #13 as scoring a 15 out of 15 on the BIMs (brief assessment for mental status) indicating the resident was cognitively intact to make daily decisions.

A physician's telephone order for Resident # 13 dated 8/13/15 documented, "X-ray of R (right) hip."

The nurse's progress note dated 8/14/15 at 4:00 p.m. documented, "Resident refused hip x-ray multiple times. RP (responsible party) aware." Further review of the nurse's progress note failed to evidence documentation of notification to the physician of resident # 13's refusal of the hip x-ray.

On 10/8/15 an interview was conducted at approximately 11:05 a.m. with ASM (administrative staff member) #1 the facility administrator and ASM # 2, director of nursing. ASM # 1 and # 2 were asked to review the nurse's progress note dated 8/14/15 at 4:00 p.m. When asked if the physician was notified of Resident # 13's refusal of the hip x-ray ASM # 1 stated, "The physician or nurse practitioner should have been notified of Resident # 13's refusal of the hip x-ray. ASM # 4, (the nurse practitioner) stated, "The physician or I should have been notified she refused. I could have spoken to her about getting the x-ray."

The facility's policy "Change in Resident Condition" documented, "The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The

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F 157	Continued From page 8 Physician/Family/ Responsible Party will be notified as soon as possible." The administrator and Director of Nursing were made aware of these findings on 10/8/15 at approximately 6:15 p.m. No further information was obtained prior to exit.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure for one of 37 residents in the survey sample, (Resident #11) was free from physical restraints. The facility staff failed to attempt a physical restraint (Geri chair [a chair that can be tilted back and prevents rising] and lap tray) reduction after an evaluation on 5/16/15 deemed Resident #11 as a good candidate. The facility staff also failed to re-evaluate the resident for a physical restraint reduction after 5/16/15. The findings include: Resident #11 was admitted to the facility on 5/2/13 with diagnoses that included but were not	F 221		

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limited to: dementia (a brain disease) and convulsions. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/12/15, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #11 as being totally dependent with bed mobility, transfers, locomotion, dressing and toilet use. Section P "Physical Restraints" coded the resident as using a chair that prevents rising on a daily basis.

An occupational therapy note dated 5/7/14 documented, "Skilled interventions include assessment of wheelchair modifications and adaptations to promote increased function and education on seating system setup to improve posture during ADL (Activities of Daily Living) performance, to improve postural stability for safe ADL performance and to enable increased participation in occupations of choice with patient cooperative with hoyer transfer and maintaining good upright posture with use of cushion, full tray, pillow underneath his legs, and supervision/nursing. CNA (certified nursing assistant) feels compliant with seating system at this time."

A physician's order summary signed on 7/7/15 documented, "LAP TRAY TO GERI CHAIR WHILE RESIDENT IS UP IN GERICHAIR FOR SAFETY RELATED TO FALLS- RELEASE LAP TRAY FOR ADL'S AND ROUNDS. RELEASE LAP TRY (sic) EVERY 2 HOURS FOR 10 MINUTES."

A physician's telephone order signed on 8/26/15 documented, "Clarification order- Lap tray to Geri chair while resident is up in Geri chair for safety

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related to falls- release lap tray for adl's and rounds. Release lap tray every 2 hours for 10 minutes."

The most recent physician's order summary signed on 9/7/15 failed to document an order for Resident #11's lap tray.

A physical restraint elimination review documented, "Directions: Individuals with restraints/enablers should be reviewed at least quarterly, or per facility policy, to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures or total restraint elimination..." The most recent review was dated 5/16/15 and documented a total score of 28, indicating Resident #11 was a good candidate for restraint reduction. Side two of the form documented, "Summarize resident's status based on strengths/weaknesses from Side One: Resident nonambulatory, poor poor (sic) safety awareness. Resident is candidate for restraint reduction: (a check mark documented beside 'yes'). Unaware of safety, will slide out of chair. Describe plan to decrease/eliminate restraints: Continue to do assessments quarterly. Describe less restrictive measures to be used: lap tray." No further reviews were completed since May 2015.

Resident #11's comprehensive care plan with an implementation date of 1/23/15 documented in part, "Safety: Lap tray to gerichair while up in chair for safety R/T (related to) Falls- Release lap tray for ADL's & rounds (Q [every] 2 hr [hours] & PRN [as needed])...Psychosocial Well being: Disruptive Behavior (specify): Bangs on table top...Behavior/Mood: Hits lap tray repeatedly..."

F 221 (D):

1. Resident #11 has been referred to therapy for evaluation regarding restraint utilization. Restraint reduction documentation has been updated. Resident # 11 no longer utilizes a geri chair with lap tray. The responsible party and the physician have been made aware of changes and the care plan has been updated.

2. Residents with physician orders for restraints have potential to be affected. Residents with restraints will have restraint reduction documentation completed. If the restraint reduction documentation indicates that the resident is a good candidate for restraint reduction, the resident will be referred to therapy for evaluation for reduction of the restraint. Restraint reduction will be attempted as indicated by the restraint reduction documentation.

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F 221	Continued From page 11 On 10/7/15 from 1:40 p.m. to 2:00 p.m., Resident #11 was observed in the bedroom, in a Geri chair with a full lap tray extending from one armrest to the other armrest. Resident #11's legs were on the footrest of the Geri chair. During this time, the resident was observed thrusting himself forward and repeatedly hitting the lap tray. At 2:00 p.m., staff removed the lap tray for approximately 10 minutes. On 10/8/15 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #11, the unit manager responsible for Resident #11's unit since July 2015. LPN #11 stated Resident #11's lap tray was used because the resident will jump out of his chair. When asked the facility process for restraint reduction, LPN #11 stated she wanted to say restraint reductions were evaluated on a quarterly basis but she didn't know when that last evaluation took place for Resident #11. When asked what should be done when a physical restraint elimination review documents a resident as being a good candidate for reduction, LPN #11 stated, "We should remove the lap tray or see how he does without the lap tray." The occupational therapist that treated Resident #11 in May 2014 was not available for interview. On 10/8/15 at 9:50 a.m., an interview was conducted with OSM (other staff member) #11 (the director of rehab), OSM #12 (the certified occupational therapy assistant who worked with Resident #11 in May 2014) and OSM #19 (the current occupational therapist). OSM #12 stated Resident #11 currently had the same lap tray that the occupational therapist gave him in May 2014. OSM #12 stated the occupational therapy staff attempted to sit the resident up in a regular	F 221	3. Staff Development Coordinator/Designee has provided education to Licensed Staff regarding completion of restraint reduction evaluation and documentation as well as restraint reduction attempts as indicated by the restraint reduction evaluation and documentation. The DCS/Designee will review restraint evaluations and documentation as well as necessity to attempt restraint reduction as indicated by the restraint evaluation/documentation weekly for (3) months. 4. The reviews will be discussed by the ED/Designee at the Quality Assurance Performance Improvement Committee monthly for (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. 11/10/15	

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER:	(X2) MULTIPLE CONSTRUCTIDN	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 12	F 221		

wheelchair but the resident was combative and pushed himself forward. OSM #12 stated staff didn't want Resident #11 stuck in bed and wanted to give him quality of life sD the occupational therapist decided to use the lap tray because it was safe. At this time, OSM #11, OSM #12 and OSM #19 cDnfirmed Resident #11 had not been evaluated by the therapy department since May 2014. OSM #19 stated the resident had nDt been referred to the therapy department since May 2014.

On 10/8/15 at 11:35 a.m., ASM (administrative staff member) #2 (the director of nursing), and LPN #11 stated they did nDt have any further inforrnation regarding Resident #11's restraint.

On 10/8/15 at 12:00 p.m., the administrator and directDr of nursing were made aware of the above findings.

The facility policy titled, "Physical Restraint and Reduction" documented, "It is the policy of The Company that all residents have the right to considerate and respectful care at all times and under all circumstances, with recognition of their personal dignity and safety in the least restrictive manner...Each resident will be reassessed a minimum of quarterly or with a change in status by interdisciplinary team. PA Specific- Each resident will be reassessed and reviewed monthly and as needed to determine whether or not the resident is a candidate for restraint reduction, least restrictive measures are being utilized or total restraint eliminatiDn is warranted. The Restraint Reduction Committee will review Dn a quarterly basis..."

No further information was presented prior to exit.

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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	495362	A. BUILOING _____ B. WING _____	C 10/08/2015

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F 225	Continued From page 14	F 225	F225 (D):	

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report investigate and report an injury of unknown origin to the state agency and other officials in accordance with State law through established procedures for one of 31 residents in the survey sample, Resident #16.

Resident #16 was observed by a nursing aide to have a new bruise located on her left inner thigh. The bruise was reported to a nurse, no other investigation was conducted regarding the bruise of unknown origin and the bruise was not reported to the state agency.

The findings include:

Resident #16 was admitted to the facility on 3/31/08 with diagnoses that included, but were not limited to: AMS (altered mental status), dementia, anxiety, hypertension, insomnia, diverticulitis (An inflammation or infection in one or more small pouches in the digestive tract), behavior disturbance, hypothyroidism (decreased thyroid function) and hyperlipidemia (increased lipids in the blood stream).
The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 8/13/15. Resident # 16 was coded as scoring three out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #16's clinical record

1. Resident #16's bruise of unknown origin was reported to the state on 10/29/2015.
2. A review of injuries for the past 30 days was conducted to determine origin and to ensure that injuries of unknown origin were properly reported to state agencies and other agencies as required. The Unit Manager/Designee will report injuries including skin discolorations to the DCS/Designee. Investigation and reporting to required agencies will be conducted as indicated.

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revealed a nurse's note dated 8/31/15 documenting, in part, the following: "8/31/15 12 p.m. (noon) Reported to nurse by CNA (certified nursing assistant) Resident (Resident #16) has purple bruise noted on L (left) inner upper thigh. Resident does not appear to be in pain. RP (responsible party) and MD (medical doctor) made aware of bruise will cont (continue) to monitor."

Further review of Resident #16's clinical record revealed a facility non-pressure skin condition record documenting, in part, the following: "Location: left inner thigh. Type: Bruise: Date: 8/31/15. Size: Length 5.5 cm (centimeters). Width 4.5 cm. Depth: NA (not applicable)."

Further review of Resident #16's clinical record revealed a facility "Bruise Root Cause Investigation Report" documenting, in part, the following documentation: "Date of occurrence: 8/31/15. Resident. Location: L inner thigh. Appearance: purple. Description: bruise. Summary: Bruise noted on L inner leg, reported to nurse by CNA."

A SBAR (situation background assessment recommendation) communication form was attached to the bruise root cause investigation report in Resident #16's clinical record. The SBAR did not provide any documentation about the cause of the bruise.

No further documentation that revealed the cause of the bruise was located in the clinical record.

An interview was conducted on 10/7/15 at 5:10 p.m. with LPN (licensed practical nurse) #10. LPN #10 was asked to describe the process

3. The Staff Development Coordinator/Designee has provided education to current employees regarding reporting injuries of unknown origin to the DCS/ED for investigation and appropriate reporting to required state agencies. Injuries will be reviewed by the DCS/Designee weekly for (3) months to ensure that they have been investigated and reported as required to state agencies.
4. Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 225	Continued From page 16	F 225		

when a bruise is observed on a resident. LPN #10 responded, "If a CNA finds a bruise while bathing or doing ADL (activities of daily living) care, I assess the area, inform the unit manager, MD (medical doctor) RP (responsible party) and do an investigation using the bruise incident report. I give the incident report to the unit manager and write a note in the progress notes and complete an SBAR." LPN #10 was then asked who completed the investigation to determine the cause of the bruise, LPN #10 responded that the unit manager would do that.

On 10/7/15 at 5:20 p.m. an interview was conducted with LPN #11, the unit manager for Wing 1, regarding the process followed when an incident report is received. LPN #11 stated, "I do an investigation. I obtain witness statements; if I am unable to determine the cause of the injury then I have to report to the state, it would be an injury of unknown origin."

On 10/7/15 an end of day meeting was held with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse consultant. The administrative staff were made aware of the above findings and asked whether or not an investigation was completed for the bruise found on Resident #16 on 8/31/15. ASM #1 stated that she would research and provide the evidence of an investigation. A policy was requested at this time that addressed injuries of unknown origin.

On 10/8/15 at 12:00 p.m. an interview was conducted with LPN #9, the unit manager on Wing 2. LPN #9 was asked whether or not she was aware of the bruise that was documented as being observed on Resident #16 on 8/31/15.

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LPN #9 stated that she was aware and the nurse practitioner had assessed the resident and the MD (medical doctor) was aware. LPN #9 was asked whether or not she had completed an investigation. LPN #9 stated, "I thought they were attached." When asked again if she had completed an investigation for Resident #16's bruise, LPN #9 stated that she did not remember. LPN #9 was then asked whether or not she was able to determine how Resident #16 obtained a bruise on her left inner thigh; LPN #9 stated that she did not know how the bruise was obtained. When asked whether or not the bruise was a reportable incident, LPN #9 stated, "It was an injury of unknown origin, it should have been reported."

On 10/8/15 at 1:30 p.m. ASM (administrative staff member) #1, the administrator, was asked whether or not an investigation had been located for the bruise found on Resident #16 on 8/31/15. ASM #1 stated, "We're getting bangs/bruises back on that unit so I don't know how they're happening. I agree that an investigation should have been done. It was not done to the point that we could have determined the cause." ASM #1 was asked whether or not the injury was reportable. ASM #1 stated, "A FRI (facility reported incident) was not done. It was an injury of unknown origin. It should have been done." ASM #1 was asked about the policy that referenced injuries of unknown origin, ASM #1 stated, "We do not reference injuries of unknown origin in our abuse policy."

A facility policy titled "Accident and Incident Investigation" dated 11/30/2014 was presented that revealed, in part, the following documentation: "Policy: Certain accidents and

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F 225	Continued From page 18 incidents, including injuries of unknown origin, will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event. Definition: Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc., which have no known cause. Procedure: 4. The executive director and director of clinical services are to be notified immediately of injuries of unknown origin. 7. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors or volunteers, which may have had contact with the resident and may help with the investigation. Obtain statements as deemed necessary. 8. All injuries of unknown origin or allegations of suspected abuse must be reported to the appropriate agencies per state specific protocols." No further information was provided prior to the end of the survey.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility policy for abuse prevention for one of 37 residents in the survey sample, (Resident #16)	F 226		

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F 226	Continued From page 19	F 226	F226 (D):	

and one of five employee record reviews, (employee record #2).

1. Resident #16 was observed by a nursing aide to have a new bruise located on her left inner thigh. The bruise was reported to a nurse, no other investigation was conducted regarding the bruise of unknown origin and the facility failed to report the bruise to the state agency.

2. The facility staff failed to do prescreening employment checks on one of five employee record reviews. A nurse's license and state criminal background check were not performed for employee record #2.

The findings include:

1. Resident #16 was admitted to the facility on 3/31/08 with diagnoses that included, but were not limited to: AMS (altered mental status), dementia, anxiety, hypertension, insomnia, diverticulitis (An inflammation or infection in one or more small pouches in the digestive tract), behavior disturbance, hypothyroidism (decreased thyroid function) and hyperlipidemia (increased lipids in the blood stream).
The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 8/13/15. Resident # 16 was coded as scoring three out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #16's clinical record revealed a nurse's note dated 8/31/15 documenting, in part, the following: "8/31/15 12

F226 (D):

1. Resident # 16 was placed on increased supervision and assessed for any further injury of unknown origin by the DCS/Designee. The background check for employee #2 was obtained on 10/8/15 during survey. Resident #16's bruise of unknown origin was reported to the state on 10/29/2015.

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F 226	Continued From page 20 p.m. (noon) Reported to nurse by CNA (certified nursing assistant) Resident (Resident #16) has purple bruise noted on L (left) inner upper thigh. Resident does not appear to be in pain. RP (responsible party) and MD (medical doctor) made aware of bruise will cont (continue) to monitor." Further review of Resident #16's clinical record revealed facility non-pressure skin condition record documenting, in part, the following: "Location: left inner thigh. Type: Bruise: Date: 8/31/15. Size: Length 5.5 cm (centimeters). Width 4.5 cm. Depth: NA (not applicable)." Further review of Resident #16's clinical record revealed a facility "Bruise Root Cause Investigation Report" documenting, in part, the following documentation: "Date of occurrence: 8/31/15. Resident. Location: L inner thigh. Appearance: purple. Description: bruise. Summary: Bruise noted on L inner leg, reported to nurse by CNA." A SBAR (situation background assessment recommendation) communication form was attached to the bruise root cause investigation report in Resident #16's clinical record. The SBAR did not provide any documentation about the cause of the bruise. No further documentation that revealed the cause of the bruise was located in the clinical record. An interview was conducted on 10/7/15 at 5:10 p.m. with LPN (licensed practical nurse) #10. LPN #10 was asked to describe the process when a bruise is observed on a resident. LPN #10 responded, "If a CNA finds a bruise while	F 226	2. A review of injuries for the past 30 days was conducted to determine origin and to ensure that injuries of unknown origin were properly reported to state agencies and other agencies as required. The Unit Manager/Designee will report injuries including skin discolorations to the DCS/Designee. Investigation and reporting to required agencies will be conducted as indicated. A review of employee records for new employees in past 30 days will be completed by the DCS/Designee for appropriate pre hire screens including Licensure and Criminal Background checks.	

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F 226	Continued From page 21	F 226	3. The DCS/Designee has provided education to current employees regarding the policy and procedure for investigating and reporting injuries of unknown origin. Education will also be provided by the Administrator/Designee to the Business Office Coordinator regarding obtaining required pre-hire screens including Licensure and Criminal Background check for new employees. Injuries will be reviewed by the DCS/Designee weekly for (3) months to ensure that they have been investigated and reported as required to state agencies. The Human Resources Director/Designee will conduct random weekly reviews of employee records for (5) employees for appropriate pre hire paperwork weekly for (3) months.	

bathing or doing ADL (activities of daily living) care, I assess the area, inform the unit manager, MD (medical doctor) RP (responsible party) and do an investigation using the bruise incident report. I give the incident report to the unit manager and write a note in the progress notes and complete an SBAR." LPN #10 was asked who completed the investigation to determine the cause of the bruise, LPN #10 responded that the unit manager would do that.

On 10/7/15 at 5:20 p.m. an interview was conducted with LPN #11, the unit manager for Wing 1, regarding the process followed when an incident report is received. LPN #11 stated, "I do an investigation. I obtain witness statements; if I am unable to determine the cause of the injury then I have to report to the state, it would be an injury of unknown origin."

On 10/7/15 an end of day meeting was held with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse consultant. The administrative staff were made aware of the above findings and asked whether or not an investigation was completed for the bruise found on Resident #16 on 8/31/15. ASM #1 stated that she would research and provide the evidence of an investigation. A policy was requested at this time that addressed injuries of unknown origin.

On 10/8/15 at 12:00 p.m. an interview was conducted with LPN #9, the unit manager on Wing 2. LPN #9 was asked whether or not she was aware of the bruise that was observed on Resident #16 on 8/31/15. LPN #9 stated that she was aware and the nurse practitioner had assessed the resident and the MD (medical

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doctor) was aware. LPN #9 was asked whether or not she had completed an investigation. LPN #9 stated, "I thought they were attached." When asked again whether or not she had completed an investigation, LPN #9 stated that she did not remember. LPN #9 was asked whether or not she was able to determine how Resident #16 obtained a bruise on her left inner thigh, LPN #9 stated that she did not know how the bruise was obtained. LPN #9 was asked whether or not the bruise was a reportable incident, LPN #9 stated, "It was an injury of unknown origin, it should have been reported."

On 10/8/15 at 1:30 p.m. ASM (administrative staff member) #1, the administrator, was asked whether or not an investigation had been located for the bruise found on Resident #16 on 8/31/15. ASM #1 stated, "We're getting bangs/bruises back on that unit so I don't know how they're happening. I agree that an investigation should have been done. It was not done to the point that we could have determined the cause." ASM #1 was asked whether or not the injury was reportable. ASM #1 stated, "A FRI (facility reported incident) was not done. It was an injury of unknown origin. It should have been done." ASM #1 was asked about the policy that referenced injuries of unknown origin, ASM #1 stated, "We do not reference injuries of unknown origin in our abuse policy."

A facility policy titled "Accident and Incident Investigation" dated 11/30/2014 was presented that revealed, in part, the following documentation: "Policy: Certain accidents and incidents, including injuries of unknown origin, will be investigated to determine root cause and provide for opportunity to decrease future

4. Results of the reviews will be discussed by the Administrator/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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occurrences of the event. Definition: Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc., which have no known cause. Procedure: 4. The executive director and director of clinical services are to be notified immediately of injuries of unknown origin. 7. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors or volunteers, which may have had contact with the resident and may help with the investigation. Obtain statements as deemed necessary. 8. All injuries of unknown origin or allegations of suspected abuse must be reported to the appropriate agencies per state specific protocols."

No further information was provided prior to the end of the survey.

2. The facility staff failed to do prescreening employment checks on one of five employee record reviews. A nurse's license and state criminal background check were not performed.

Review of the employee record #2, revealed the employee's nursing license and a state criminal background check were not completed prior to hire.

The missing information was requested from OSM #1 (other staff member) on 10/7/15 at 4:06 p.m.

The administrative team was made aware of these findings on 10/7/15 at 6:14 p.m.

An interview was conducted with other staff member (OSM) #1, human resources, on 10/08/15 at 9:30 a.m. When asked where the

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F 226	Continued From page 24 license check and the criminal background check was for (employee record #2), OSM #1 stated, "She came in as a non-clinical position, as a case manager, and recently went to a clinical position. I pulled her license yesterday and the police check was not done prior." A copy of the job description was requested. On 10/08/15 at 10:15 a.m. OSM #1 presented the job description for employee record #2. The job description documented, "Case Manager - Education - Degree in nursing preferred and/or equivalent experience in Healthcare Management." When asked if someone has a degree in nursing, then shouldn't they have an active license, OSM #1 stated, "Yes, we should have checked it." The facility policy, Eligibility for Employment, documented, "Criminal Convictions: Individuals who have been convicted of any offense involving theft, violence, physical harm or mental harm to another individual, drug-related offenses or any other offense which raises an issue of potential risk to residents, patients or other employees may not be eligible for hire or continued employment.....Any individual who has been found to be guilty by any state or federal agency of abuse or neglect of a patient or resident in any health care setting is not eligible for employment." No further information was provided prior to exit.	F 226		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing	F 252		

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the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to maintain a clean comfortable homelike environment for two of 37 residents in the survey sample (Residents #1 and #11) and one of three units (wing three) and in 17 of 98 resident rooms, (resident rooms 113B, 122, 213B, 218B, 314, 318A, 320B, 324, 240B, 300, 301, 302, 303, 308, 312, 313B and 330).

1. The facility staff failed to maintain Resident #1's room in a clean manner.

2. The facility staff failed to maintain Resident #11's Geri chair armrest in good repair.

3. On 10/6/15, 10/7/15 and 10/8/15, a strong urine odor was noted in the unsecured portion of the hallway on wing three, and in the secured portion of the hallway on wing 3, (the dementia unit hallway) and resident rooms on the dementia unit.

4. Multiple areas and items were observed in need of repair and or cleaning in resident rooms 113B, 122, 213B, 218B, 314, 318A, 320B, 324, 240B, 300, 301, 302, 303, 308, 312, 313B and 330.

The findings include:

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1. The facility staff failed to maintain Resident #1's room in a clean manner.

Resident #1 was admitted to the facility on 6/6/14 with diagnoses that included but were not limited to: diabetes (a blood sugar disease) and quadriplegia (paralysis of both arms and both legs). Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/24/15, coded the resident as being cognitively intact, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) interview. The resident was coded as being totally dependent on two or more staff for bed mobility, transfers, dressing and bathing.

On 10/7/15 at 9:30 a.m., Resident #1 voiced concern regarding the cleanliness of his room. The following was observed:

One piece of a candy wrapper on the floor.
One piece of a paper towel on the floor.
Two balls of hair on the floor.
One blue cap on the floor.
Dirt on the floor.
Black and brown stains on the floor.
Film of dust on top of the air conditioning/heating unit.
Dust and brown stains on the light over the bed.
One piece of yellow wrapper on the floor.
Food crumbs on the floor.
Film of dust on the baseboard behind the bed.
Dirt, hair and food crumbs on the base of the over bed table.

During the above observation, Resident #1 stated his room was worse than a prison and he knew this because he previously worked at a prison.

1. Resident #1's room has been cleaned. Resident #11 Geri chair armrest was replaced. Wing 3 unsecure portion and secured portion strong urine smell was eliminated. Room number 113B, 122, 213B, 314, 318A, 320B, 324, 240B, 300, 301, 302, 303, 308, 312, 313B and 330 were all cleaned. Items identified in need of repair were corrected. Room number 300, 301, 302, 303, 306, 312, 313, 328 and 330 resident room / bathrooms were cleaned to address the urine odor.
2. Environmental rounds/observations have been conducted throughout the facility to ensure resident areas are safe/clean/comfortable/ and that the environment is homelike.

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F 252	Continued From page 27	F 252	3. Housekeeping employees have received education from the Administrator/Designee regarding cleaning of resident rooms. Current employees have received education from the Administrator/Designee regarding identifying and reporting items in need of repair to maintenance staff. Maintenance employees have received education regarding policy related to obtaining concerns from maintenance logs on nursing units and conducting environmental rounds throughout the facility to identify potential environmental areas of concern. The Administrator/Designee will conduct observations for (10) rooms (5) times per week for (3) months to observe for and identify odors, items in need of repair, and concerns regarding cleanliness.	

Resident #1 stated, "I feel like a prisoner; a neglected prisoner. I am confined. I can't move and clean."

On 10/7/15 at 5:29 p.m., an interview was conducted with OSM (other staff member) #14, the director of housekeeping and laundry. OSM #14 was asked the facility process for cleaning resident rooms. OSM #14 stated every day, staff do a walk through and spot check each room. OSM #14 stated staff cleans resident rooms every day using the five and seven step process. OSM #14 stated staff cleans the sink, mirrors, floors and dust the top of the air conditioning/heating units, baseboards and over bed lights. At this time, OSM #14 was shown Resident #14's room. During this time, all of the above concerns remained present. This surveyor removed a film of dust off the top of the air conditioning/heating unit with one finger. OSM #14 stated, "Wow." OSM #14 was shown the floor. This surveyor removed a film of dust off the baseboard with one finger. OSM #14 stated, "I totally agree." OSM #14 stated the person formerly responsible for cleaning the room no longer cleaned the room and someone new was cleaning the room.

On 10/7/15 at 6:35 p.m., the administrator and director of nursing were made aware of the above findings.

The facility document titled, "5-Step Daily Patient Room Cleaning" documented, "PURPOSE: To show Housekeeping employees the proper cleaning method to sanitize a patient's room or any area in a healthcare facility. Start with a properly stacked cart. Use proper Personal Protective Equipment. 5-Step Patient Room

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F 252	Continued From page 28 Cleaning Procedure: 1. Empty Trash: Collect trash from all rooms as a first priority. Replace liner as need. Sanitize the trash can daily. Be aware of sharps or other potentially hazardous materials in trash. 2. Horizontal Surfaces-disinfected: Using a solution of properly diluted germicide, sanitize all horizontal surfaces. As you enter the room, work clockwise around the room hitting all surfaces. Table tops, headboards, window sills, chairs- should all be done. 3. Spot Clean Walls: Vertical surfaces are not completely wiped down daily- but must be spot-cleaned daily. Walls- especially by trash cans, light switches and door handles- will need special attention. 4. Dust Mop: The entire floor must be dust mopped-especially behind dressers and beds. Employees should never damp mop a floor before it has been dust mopped. Move all furniture to dust mop. All corners and along all baseboards must be dust mopped to prevent buildup. When water pushes dust into corners, problems occur. 5. Damp Mop: Remember- The procedure is to 'damp mop' - not wet mop. The most important area of a patient's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily. As with dust mopping, start in the far corner of the room, move all furniture necessary, and run the mop along the edges first. Never push the mop into a corner. That will only lead to a build up. Using a figure 8 motion, work your way out of the door. Do not forget to use 'Wet Floor' signs." The facility document titled, "7-Stepts Daily Room Cleaning" documented, "1. EMPTY TRASH. Reline receptacles and sanitize as needed. 2. HORIZONTAL SURFACES. Clean and dust using an approved Germicide: windowsills, bed rails, headboards, tables, chairs, dressers, and	F 252	4. The results of the observations will be discussed by the Administrator/Designee in the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. 11/10/15	

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bedside tables. 3. SPOT CLEAN WALLS. Clean: light switches, doors & frames, pictures, etc. 4. DUST MOP FLOOR. Move furniture as you go. Take care sweeping under beds. 5. DAMP MOP FLOOR. 6. CLEAN BATHROOM FIXTURES. 7. PERSONNEL INSPECTION (REFILL SUPPLIES). Make sure water is clean and mixture is correct. Change mop water every 3 rooms or more often as needed. Move furniture as you work your way out. Utilize wet floor signs."

No further information was presented prior to exit.

2. The facility staff failed to maintain Resident #11's Geri chair armrest in good repair.

Resident #11 was admitted to the facility on 5/2/13 with diagnoses that included but were not limited to: dementia (a brain disease) and convulsions. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/12/15, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #11 as being totally dependent with bed mobility, transfers, locomotion, dressing and toilet use.

On 10/7/15 at 1:40 p.m., Resident #11 was observed in a Geri chair in the bedroom. Two torn areas (with cloth and foam exposed) were observed on the right armrest of the Geri chair. The first area was approximately one inch long by one inch wide. The second area was approximately one and a half feet long by two inches wide.

On 10/7/15 at 4:25 p.m., an interview was

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conducted with CNA (certified nursing assistant) #8 When asked the facility process for ensuring equipment such as wheelchair and Geri chairs are in good repair, CNA #8 stated, "If we see something, we inform maintenance and they fix it."

On 10/7/15 at 4:40 p.m., CNA #8 was shown Resident #11's Geri chair armrest. CNA #8 stated the armrest should be like the other armrest.

On 10/7/15 at 5:29 p.m., an interview was conducted with OSM (other staff member) #9, the director of maintenance. OSM #9 stated his department power washes wheelchairs and Geri chairs once a week. OSM #9 stated the wheelchairs and Geri chairs on wing (number of facility wing) (Resident #11's wing) are washed every Monday.

On 10/7/15 at 5:55 p.m., another interview was conducted with OSM #9. OSM #9 stated his assistant put some new Geri chairs together and took the chairs to the therapy department on the previous Friday (10/2/15). OSM #9 stated he wasn't aware of any particular resident that needed a new Geri chair.

On 10/7/15 at 6:00 p.m., an interview was conducted with OSM #11, the director of rehabilitation. OSM #11 stated he was not recently made aware of anyone who needed a new Geri chair. OSM #11 stated no one has come to him regarding Resident #11's Geri chair armrests.

On 10/7/15 at 6:35 p.m., ASM (administrative staff member) #1, the administrator and director

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of nursing were made aware of the above findings. ASM #1 was asked how staff ensures torn wheelchair and Geri chair armrests are free from contamination and bacteria. ASM #1 stated, "I don't know."

The facility policy titled, "Maintenance" documented in part, "The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identify areas/items in need of repair...All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form. The form will be completed and placed in a designated area on the nursing unit or in the maintenance office. Environmental Services personnel will check for completed forms throughout the day. The Requests will be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and future resolution..."

No further information was presented prior to exit.
3. On 10/6/15, 10/7/15 and 10/8/15, a strong urine odor was noted in the unsecured portion of the hallway on wing three, and in the secured portion of the hallway on wing 3, (the dementia unit hallway) and resident rooms on the dementia unit.

Resident #1 was admitted to the facility on 6/6/14 with diagnoses that included but were not limited to: diabetes (a blood sugar disease) and quadriplegia (paralysis of both arms and both legs). Resident #1's most recent MDS (minimum

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data set), a quarterly assessment with an ARD (assessment reference date) of 8/24/15, coded the resident as being cognitively intact, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) interview. On 10/7/15 at 6:05 p.m., an Interview was conducted with Resident #1 regarding urine odors in the facility. Resident #1 stated, "It reeks in the hallways." When asked how the urine odors made him feel, Resident #1 stated, "I feel horrible. My mom and friends notice it. It's embarrassing. My kids don't come anymore."

On 10/6/15 at approximately 2:00 p.m., 10/7/15 at approximately 8:10 a.m. and 10/8/15 at approximately 8:15 a.m., observations of the secured dementia unit hallway and resident rooms was conducted. A urine odor was noted in the hallway and in the following resident rooms/bathrooms: 300, 301, 302, 303, 306, 312, 313, 328 and 330.

On 10/6/15 at approximately 2:00 p.m., 10/7/15 at approximately 8:10 a.m. and 10/8/15 at approximately 8:15 a.m., a strong urine odor was observed in the hall on the unlocked portion of wing 3 while walking from the end of the hall toward the nurse's desk.

On 10/6/15 at 5:00 p.m., a strong urine odor was observed in the hall on the unlocked portion of wing 3 while walking from the end of the hall toward the nurse's desk.

On 10/8/15 at 9:15 a.m., observations of the hallway on wing three and the secured dementia unit hallway and resident rooms was conducted with OSM (other staff member) # 9, director of environmental services and OSM # 10,

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housekeeping district manager. The following was noted in resident rooms/bathrooms:
· 300/301- OSM #9 and # 10 confirmed urine odor in the bathroom and room.
· 302/303/306/312/313 OSM - #9 and # 10 confirmed urine odor in the bathroom.
· 328/330- OSM #9 and # 10 confirmed urine odor in the bathroom and room.

On 10/7/15 at 1:45 p.m., a group interview was conducted with eight residents. The residents stated they did notice urine odors in the facility and staff was always cleaning.

On 10/8/15 at 10:10 a.m., an interview was conducted with OSM # 9, director of environmental services and OSM # 10, housekeeping district manager regarding cleaning of the resident's rooms and the urine odors. OSM #10 stated the housekeeping department was responsible for cleaning resident rooms/bathrooms and they are cleaned three times a days and as needed. In regard to the urine odor OSM # 10 stated, "Once the urine gets under the floor or tiles it's hard for us to neutralize the odor. OSM # 9 stated, "We have a plan in place to replace the tile flooring in the resident's bathrooms with a single piece of vinyl flooring to prevent urine from seeping under the flooring." OSM # 9 further stated that they had not started replacing the bathroom floors and that the administration was aware of the problem.

On 10/8/15 at approximately11:30 a.m., the Administrator was made aware of the above findings.
The facility contracted housekeeping company's policy titled "7 - Steps Daily Room Cleaning / Bathroom" revealed nothing pertinent to these

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findings.
No further information was presented prior to exit.

COMPLAINT DEFICIENCY

4. Multiple areas and items were observed in need of repair and or cleaning in resident rooms 113B, 122, 213B, 218B, 314, 318A, 320B, 324, 240B, 300, 301, 302, 303, 308, 312, 313B and 330
Observations of resident's rooms were conducted on 10/6/15 at approximately 2:00 p.m., 10/7/15 at approximately 8:10 a.m. and 10/8/15 at approximately 8:15 a.m. The observations revealed the following:

- Room 113 B - a missing drawer pull on three drawer dresser.
- Room 122 - a missing drawer pull on four drawer dresser.
- Room 213 B - on the outside wall an approximate six foot section of cove base wall molding was falling off the wall and the wall behind the cove base was rotted and crumbling.
- Room 218 B - the bedside table had a missing piece of trim between the first and second drawers.
- Room 314 - paint peeling off the face of the closet unit.
- Room 318 A - drawer pull hanging off a drawer on the bedside table.
- Room 320 B - a missing drawer pull on three drawer dresser.
- Room 324 - two plastered areas behind the room door measuring nine by six inches and seven by six inches were unfinished and unpainted.
- Room 240 B - drawer pull hanging off a drawer on the bedside table.
- Room 300 bathroom - dark brown substance

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covering the caulk around the base of the toilet.
· Room 301 bathroom - dark brown substance covering the caulk around the base of the toilet.
· Room 302 bathroom - dark brown substance covering the caulk around the base of the toilet.
· Room 303 bathroom - dark brown substance on the pedestal of the toilet and covering the caulk around the base of the toilet and damage to the wall behind the toilet.
· Room 308 - bedside table missing drawer pull.
· Room 312- dark brown substance covering the caulk around the base of the toilet.
· Room 313 B - the wall behind the head of the bed revealed two unfinished and unpainted plastered areas measuring approximately sixteen inches by seven and a half inches and nine and a half inches by six inches.
· Room 330 bathroom - dark brown substance on the bathroom door frame, a piece of plywood covering and fastened over the bathtub with un-sanded and sharp edges on the exterior edge, globe missing from the ceiling light fixture and a brown stained ceiling tile.

On 10/8/15 at 9:15 a.m., observations of resident rooms 113B, 122, 213B, 218B, 314, 318A, 320B, 324, 240B, 300, 301, 302, 303, 308, 312, 313B and 330 was conducted with OSM (other staff member) # 9, the director of environmental services and OSM # 10 the housekeeping regional director. All the areas listed above were pointed out to OSM # 9 and # 10. OSM # 9 and # 10 agreed and acknowledged the observations, concerns and stated that the items needed to be cleaned and /or fixed. OSM # 9 acknowledged that the edge of the wood on the plywood covering the bathtub in the bathroom for Room 330 was unfinished and was sharp and could

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injury a resident. OSM # 9 stated. "The plywood over the tub should be replaced to eliminate the sharp edge."

On 10/8/15 at approximately 10:10 a.m. an interview was conducted with OSM # 9 regarding general repairs within the facility by the maintenance department. OSM # 9 was asked how the maintenance department is notified of repairs or possible hazards in the residents rooms. OSM # 9 stated, "We rely on the mock survey that is conducted by the facility staff every Monday to tell us what needs to be fixed in the residents rooms. Each maintenance staff is assigned to a wing of the facility and is responsible for those repairs." When asked if the maintenance department uses a work order system OSM # 9 stated, "Each wing has a maintenance logbook and it is checked at least three times a week, it should be checked daily." OSM #10 stated the housekeeping department was responsible for cleaning resident rooms/bathrooms and they are cleaned three times a days and as needed.

The facility's policy "Maintenance" documented in part, "The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition."

The facility contracted housekeeping company's policy titled, "7 - Steps Daily Room Cleaning / Bathroom" revealed nothing pertinent to these findings.

On 10/8/15 at approximately11:30 a.m., the Administrator was made aware of the above findings.

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F 252	Continued From page 37 No further information was presented prior to exit.	F 252		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review and clinical record review it was determined that facility staff failed to provide location and date of information for CAA (Care Area Assessment) triggered areas on a comprehensive MDS (minimum data set) assessment for three of 37 residents in the survey sample, Resident #10, #5, and #12.

1. For Resident #10, facility staff failed to provide location and date of information on the CAA (Care Area Assessment) Summary Worksheet for the annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/25/14.

2. For Resident #5, the facility staff failed to document the location and date on the CAA (Care Area Assessment) Summary Worksheet for the significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/8/15.

3. For Resident # 12, the facility staff failed to document the location and date on the CAA (Care Area Assessment) Summary Worksheet for the annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 6/25/15.

The findings include:

1. For Resident #10, facility staff failed to provide location and date of information on the CAA (Care

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F 272	Continued From page 39 Area Assessment) Summary Worksheet for the annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/25/14. Resident #10 was admitted to the facility on 12/29/2008 and readmitted on 3/30/14 with diagnoses that included but were not limited to Alzheimer's disease, hypothyroidism, osteoporosis, rectal cancer, rheumatoid arthritis, and major depressive disorder. Resident #10 most recent MDS was a quarterly review assessment with an ARD of 8/16/15. Resident #10 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 0 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #10 was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene, toileting and bathing. A review of the clinical record revealed that the most recent comprehensive MDS was an annual assessment with an ARD of 11/25/14. This review revealed in Section V (Care Area Assessment (CAA) Summary), a column, titled "Location and Date of CAA documentation." The following areas were triggered: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, and Pressure. The following was documented under location and date for the triggered care area of cognitive loss, "CAA WS (worksheet) dated 12/4/2014." Review of the CAA worksheets dated 12/4/14 failed to reveal date and location of information for the triggered care area cognitive loss.	F 272	F 272 (D): 1. Residents #10, #5, and #12 have received modifications of comprehensive assessments and Care Area Assessment sections; Resident #10 Annual Assessment ARD 11/25/2014 CAA triggered for Cognitive Loss completed to include date and location of documentation ; Resident #5 Significant Change Assessment ARD 2/8/2015 CAA triggered for Cognitive Loss completed to include date and location of documentation; Resident #12 Annual Assessment ARD 6/25/2015 CAAs triggered for Cognitive Loss and Dietary completed to include date and location of documentation.	

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F 272	Continued From page 40 On 10/7/15 at 8:57 a.m., an interview was conducted with ASM (administrative staff member) # 1, the administrator regarding the staff member that completed the CAA worksheet for the triggered area cognitive loss on Resident #10. ASM #1 stated, "This staff member is a traveling MDS coordinator. She is not in the building at this time. I will try to locate her." On 10/7/15 at 9:01 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the MDS coordinator. When asked the process of date and location of information for CAA triggered areas she stated, "Generally what we do is review the medical record such as the physician order sheet, MAR etc. and when an area is triggered on the MDS we will locate where in the medical record supports the triggered area. We also reference the time period where we found information." LPN #2 was shown Resident #10's MDS and CAA worksheets. She stated, "I don't see date and location, let me peep at it in the computer." At 9:06 a.m. she stated, "She just didn't reference it. Something should have been addressed." LPN #2 stated that they use the RAI (Resident Assessment Instrument) when completing the MDS and CAA worksheets. On 10/7/15 at 8:57 a.m. administration was made aware of the above concerns. No further information was provided during the time of survey. Section V of the MDS documents at the top of the page the following instructions: 1. Check column A if the Care Area is triggered.	F 272	2. Residents that currently reside in the facility have the potential to be affected. Minimum Data Set review of CAAs for comprehensive assessments that have been completed within the last three months will be conducted by Regional Case Mix Coordinator/Designee(s).	

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2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.

3. Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks and any referrals for this resident for this care area.

Review of CMS's (Center of Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 User's Manual documented, "CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING. 4.5 Other Considerations Regarding Use of the CAAs. Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan."

2. For Resident #5, the facility staff failed to document the location and date on the CAA (Care Area Assessment) Summary Worksheet for the significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/8/15.

F 272

3. The Interdisciplinary Team has been educated by RCMC (Regional Case Mix Coordinator) on the proper completion of the CAAs for comprehensive assessments. Random weekly reviews will be completed by the Minimum Data Set Coordinator/Designee for (5) residents per week for (3) months to ensure that the CAAs are completed and the date and location of the information included in the CAAs is indicated.
4. Results of the random weekly reviews will be discussed by the Administrator/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
5. 11/10/2015

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Resident #5 was admitted 5/13/14 with the diagnoses of but not limited to multiple sclerosis, encephalopathy, depression, bipolar, anxiety and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/8/15. The resident was coded as being mildly cognitively impaired in ability to make daily life decisions, scoring an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for dressing and hygiene; limited assistance for transfers; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed the most recent comprehensive MDS (a significant change MDS with an ARD of 2/8/15). Under Section V (the CAA Summary section) (CAA - Care Area Assessment), the following were documented as being a triggered area (as evidenced by an "X" in the box for column "A - Care Area Triggered"): Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain.

Under the column for "Location and Date of CAA documentation" for Cognition, was documented, "CAA WS dated 2/18/15." Review of the CAA worksheet failed to reveal the date and location of information as obtained from the clinical record to complete this section.

On 10/7/15 at 2:34 p.m., in an interview with OSM #5 (Other Staff Member #5, the social worker)

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she stated that she "should probably have documented where in the nurse's notes." She stated she had no formal training and was not shown to do that.

On 10/7/15 at 5:30 p.m., the Administrator and DON (Director of Nursing) was made aware of the findings. No further information was provided by the end of the survey.

3. For Resident # 12, the facility staff failed to document the location and date on the CAA (Care Area Assessment) Summary Worksheet for the annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 6/25/15.

Resident #12 was admitted to the facility on 2/13/12 with diagnoses that included but were not limited to: depression, prostate cancer, atrial fibrillation, osteoarthritis, psychosis, dementia, post traumatic stress disorder, anemia, high blood pressure, dysphagia and chronic obstructive pulmonary disease.

The most recent MDS assessment, a quarterly assessment, with an ARD of 9/25/15, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one to two staff members for all of his activities of daily living.

Review of the CAA Summary for the annual assessment, with an ARD of 6/25/15 was conducted. Documented under the column, "Location and Date of CAA Documentation," was the following:
"02. Cognitive Loss/Dementia - CAA WS (worksheet) dated 7/1/15
09. Behavioral Symptoms - CAA WS dated 7/1/15

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F 272	Continued From page 44 12. Nutritional Status - CAA WS dated 6/26/15." Review of the CAA worksheet for Cognitive loss/dementia, behavioral symptoms and nutritional status did not reveal any documentation as to the location and the dates from which the information used to complete the assessment was located. An interview was conducted with LPN (licensed practical nurse) #2, the MDS coordinator, on 10/7/15 at 11:45 a.m. When asked who is responsible for the completion of cognition and behavioral CAAs on the MDS, LPN #2 stated the social workers are responsible for that area on the CAAs on the MDS. When asked who was responsible for the nutritional status CAA summary, LPN #2 stated that the dietician is the one completing that section of the MDS. An interview was conducted on 10/7/15 at 11:50 a.m. with other staff member (OSM) #2, the social worker. When asked where the documentation of the information used to complete the CAA summary was located, OSM #2 stated, "Typically I write in the information on the CAA worksheet. I pull it from the chart notes. I didn't write which dates or notes I used." When asked what training she has had to complete the MDS and CAA summary, OSM #2 stated, "I didn't get any official training; I talk to the MDS coordinators if I have any questions. I didn't get someone to sit down with me and explain it." When asked if she has any questions, does she have a reference she can refer to, OSM #2 stated, "If I have any questions I just ask the MDS nurses." The administrative team was made aware of the	F 272		

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F 272	Continued From page 45 above findings on 10/7/15 at 6:14 p.m. An interview was conducted with OSM #3, the dietician, on 10/8/15 at 8:51 a.m. When asked where the documentation of the information used to complete the CAA summary was located, OSM #3 stated, "I was not taught how to complete the MDS. I go to four facilities and I pick up information as I go. I pick the MDS nurse's brains for questions." When asked if she had a reference book or resource to go to, OSM #3 stated, "No." No further information was provided prior to exit.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		

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resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) assessment for four of 37 residents in the survey sample; Residents #5, #19, #10, #11.

1. For Resident #5, the facility staff failed to code the quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/8/15, for a fall that occurred on 3/28/15.

2. Resident #19 was incorrectly coded on her quarterly MDS assessment with an ARD of 7/2/15 as being continent of bladder, Resident #19 was incontinent of bladder during the ARD seven day lookback.

3. Facility Staff failed to properly code section O0300 (Pneumococcal Vaccine) on a quarterly MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 8/16/15 and on an annual MDS assessment with an ARD of 11/25/14, for Resident #10.

4. The facility staff failed to accurately code section D of Resident #11's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/12/15.

F 278 (D):

1. Residents # 5 has received modification to the quarterly assessment ARD 5/8/2015, regarding Section J 1900 ; Resident #19 has received modification to quarterly assessment ARD 7/2/2015 regarding section H; Resident #10 has received modification to quarterly assessment ARD 8/16/15 regarding Section O, question O0300B; as well as the annual assessment ARD 11/25/14 Resident #11 has received a modification to quarterly assessment ARD 7/12/2015 for Section D.

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F 278	Continued From page 47	F 278	2. Residents that currently reside in the facility have the potential to be affected. Minimum Data Set review will be conducted by the Minimum Data Set Coordinator/Designee of MDS's completed within the last 90 days. This review will include ensuring that the MDS is coded accurately for falls Section J 1900, Section H regarding continence status, Section O regarding Pneumococcal Vaccinations, and Section D.	

The findings include:

1. For Resident #5, the facility staff failed to code the quarterly MDS with an ARD of 5/8/15, for a fall that occurred on 3/28/15.

Resident #5 was admitted 5/13/14 with the diagnoses of but not limited to multiple sclerosis, encephalopathy, depression, bipolar, anxiety and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/8/15. The resident was coded as being mildly cognitively impaired in ability to make daily life decisions, scoring an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for dressing and hygiene; limited assistance for transfers; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed an "SBAR" (situation, background, assessment, request) form dated 3/28/15. This form documented that Resident #5 had a fall without injury on that date. The note documented, "Res (resident) parked w/c (wheelchair) in hallway & (and) walked to her rm (room) closet & eased herself to the floor Ø (no) injury Ø c/o (complaints of) pain skin warm dry & intact neuro (neurological) check in place Res is own RP (responsible party) & has informed staff she does not wish to go to the hospital for eval (evaluation) & tx (treatment) MD (medical doctor) aware N.O. (new order) prescribed alarm while in wheelchair." [sic all one run-on sentence.]

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	495362	A. BUILDING _____ B. WING _____	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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A review of the 5/8/15 quarterly MDS (the first MDS following the fall) revealed the fall was not coded.

On 10/7/15 at 4:33 p.m., in an interview with LPN #1 (Licensed Practical Nurse #1, MDS nurse), she stated, "If this is the first MDS following the fall, it should be (the fall) coded on it." On 10/8/15 at 8:08 a.m., LPN #1 stated, "I should have coded it for a fall. It was on my worksheet."

On 10/7/15 at 5:30 p.m., the Administrator and DON (Director of Nursing) was made aware of the findings. No further information was provided by the end of the survey.

2. Resident #19 was incorrectly coded on her quarterly MDS assessment with an ARD of 7/2/15 as being continent of bladder, Resident #19 was incontinent of bladder during the ARD seven day look back.

Resident #19 was admitted to the facility on 4/30/15 with a readmission on 6/18/15, with diagnoses that included, but were not limited to: epilepsy (a form of seizures), anxiety, hypertension, depression, pain and ulcer. The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 9/8/15. Resident # 19 was coded as scoring two out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #19's quarterly MDS

F 278

3. The Interdisciplinary Team has been educated by RCMC (Regional Case Mix Coordinator)/Designee on sections J, H, O, and D of the MDS and will include completion of those sections according to the RAI manual. Random weekly review of the MDS by the MDSC/Designee for (5) residents per week for (3) months will be completed to ensure that the MDS is accurately coded for Sections J, H, O, and D.
4. Results of these reviews will be discussed in the QAPI Committee Meeting by the Administrator/Designee monthly for (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
5. 11/10/2015

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assessment with an ARD of 7/21/15 revealed in Section H, Bladder and Bowel, that Resident #19 was coded as always continent. This assessment was compared to Resident #19's quarterly MDS assessment with an ARD of 9/8/15 on which Section H, Bladder and Bowel, Resident #19 was coded as always incontinent.

Review of Resident #19's clinical record did not reveal any documentation that evidenced that Resident #19 had a significant change in bladder function between 7/21/15 and 9/8/15.

On 10/8/15 at approximately 10:00 a.m. an interview was conducted with LPN (licensed practical nurse) #12, the MDS coordinator. LPN #12 was asked when completing Section H on the MDS where she obtained her information. LPN #12 responded, "I look at the ADL (activities of daily living) documentation, the restorative nursing notes and staff interview." LPN #12 was asked to describe her process if there was a significant change noted from one MDS to another. LPN #12 stated, "If there's an obvious decline we discuss with IDT (interdisciplinary team), we monitor the change to see if it is self resolving." LPN #12 was asked about the change documented on Resident #19's MDS for bladder function. LPN #12 stated, "I don't know what happened regarding the change in bladder continence." LPN #12 asked for time to research this change.

On 10/8/15 at 12:05 p.m. LPN #12 returned to this surveyor and stated, "My coding was inaccurate, she (Resident #19) has always been incontinent and she was incontinent during the 7/21/15 MDS assessment. I have already submitted a correction." LPN #12 was asked

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what she used as a reference when completing the MDS assessments. LPN #12 responded, "I use the RAI (resident assessment instrument) manual.

On 10/8/15 at 1:00 p.m. ASM (administrative staff member) #1, the administrator, was made aware of these findings. No further information was provided prior to the end of the survey.

3. Facility Staff failed to properly code section O0300 (Pneumococcal Vaccine) on a quarterly MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 8/16/15 and on an annual MDS assessment with an ARD of 11/25/14, for Resident #10.

Resident #10 was admitted to the facility on 12/29/2008 and readmitted on 3/30/14 with diagnoses that included but were not limited to Alzheimer's disease, hypothyroidism, osteoporosis, rectal cancer, rheumatoid arthritis, and major depressive disorder. Resident #10's most recent MDS was a quarterly review assessment with an ARD of 8/16/15. Resident #10 was coded as being severely cognitively impaired in the ability to make daily life decisions scoring 0 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #10 was coded as being totally dependent on staff with transfers, dressing, eating, personal hygiene, toileting and bathing.

A Review of Resident #10's most recent quarterly MDS assessment with an ARD of 8/16/15 and most recent comprehensive MDS, an annual MDS with an ARD of 11/25/14 was conducted. Section O0300 (Pneumococcal Vaccine) of both

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MDS assessments documented the following:
"A. Is the resident's Pneumococcal vaccine up to date?
0. Noè Continue to O03008, If pneumococcal vaccine not received, state reason
1. Yes à Skip to O0400. Therapies.
B. If Pneumococcal vaccine not received, state reason:
1. Not eligible-medical condition.
2. Offered and declined.
3. Not offered. "
"0" was documented under A of section O indicating that the resident had not received the vaccination.
"-"(dashes) were documented under B of section O indicating that the questions were not answered or assessed.
Further review of Resident #10's clinical record revealed an informed consent for pneumococcal vaccine that was signed by the resident's responsible party on 8/19/14. This form documented that the responsible party gave the facility consent to administer the vaccination. The form documented the following: "I hereby give the facility permission to administer a pneumococcal vaccination, unless medically contraindicated. To the best of my knowledge, I have not received a pneumococcal vaccination in the past five years."
Further review of the clinical record revealed that Resident #10 had not received the pneumococcal vaccination until 9/8/15.
On 10/7/15 at 8:20 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the MDS coordinator. When asked what the dashes meant on the MDS assessments for Resident #10, she stated, "The dashes mean that none of these responses applied to the resident. The vaccination was offered but she was not given it yet so we could not choose choice

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number 2 because the RP (responsible party) did not decline the vaccine." She stated, "We also could not do choice number 3 (not offered) because the RP signed the consent form. That means we offered it." LPN #2 was asked why Resident #10 was not offered the vaccine after the consent form was signed. LPN #2 stated, "I think we were waiting for clarification because she was given Prevnar." LPN #2 stated that she used the RAI (Resident Assessment Instrument) manual.
On 10/7/15 at 8:57 a.m., administration was made aware of the above findings. No further information was presented during the time of survey.
According to the RAI manual:
"Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?

· Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, If Pneumococcal vaccine not received, state reason.
· Code 1, yes: if the resident's pneumococcal vaccination status is up to date. Skip to O0400, Therapies.

Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason If the resident has not received a pneumococcal vaccine, code the reason from the following list:

- Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.

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F 278	Continued From page 53 - Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine. - Code 3, Not offered: resident or responsible party/legal guardian not offered the pneumococcal vaccine. 4. The facility staff failed to accurately code section D of Resident #11's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/12/15. Resident #11 was admitted to the facility on 5/2/13 with diagnoses that included but were not limited to: dementia (a brain disease) and convulsions. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/12/15, coded the resident as sometimes being understood and as sometimes understanding verbal content. Section C coded Resident #11's cognitive skills for daily decision making as severely impaired. Section D of Resident #11's MDS documented, "D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents." A dash was coded. All questions related to the mood interview in sections D0200 and D0300 were also coded with dashes. On 10/7/15 at 2:35 p.m., an interview was conducted with OSM (other staff member) #5, (social worker) the person responsible for completing section D of Resident #11's MDS. OSM #5 stated she attempts the mood interview with everyone. OSM #5 was shown Resident	F 278		

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#11's MDS. OSM #5 stated she should have coded "Yes" in section D0100 to indicate she attempted the interview and she should have coded "No response" in section D0200. OSM #5 stated she didn't know why she coded dashes. OSM #5 stated she may have accidentally coded the dashes and didn't double check the coding. OSM #5 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual.

On 10/7/15 at 6:35 p.m., the administrator and director of nursing were made aware of the above findings.

The CMS RAI manual documented the following:

"SECTION D: MOOD
Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable...

D0100: Should Resident Mood Interview Be Conducted?
Coding Instructions
·Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
·Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for

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whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©)...

D0200: Resident Mood Interview (PHQ-9©)
Coding Instructions for Column 1. Symptom Presence
·Code 0, no: if resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
·Code 1, yes: if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
· Code 9, no response: if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.
Coding Instructions for Column 2. Symptom Frequency
Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.
·Code 0, never or 1 day: if the resident indicates that he or she has never or has only experienced the symptom on 1 day.
·Code 1, 2-6 days (several days): if the resident indicates that he or she has experienced the symptom for 2-6 days.
·Code 2, 7-11 days (half or more of the days): if the resident indicates that he or she has experienced the symptom for 7-11 days.
·Code 3, 12-14 days (nearly every day): if the resident indicates that he or she has experienced the symptom for 12-14 days...

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F 278	Continued From page 56 D0300: Total Severity Score Coding Instructions ·The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©. ·If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as '99' and the Staff Assessment of Mood should be conducted. ·Enter the total score as a two-digit number. The Total Severity Score will be between 00 and 27 (or "99" if symptom frequency is blank for 3 or more items). ·The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9© Total Severity Score Scoring Rules..." No further information was presented prior to exit.	F 278		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for four of 37 residents in the survey sample, Residents #12, #2, #27, and #6. 1. The facility staff failed to ensure the recapitulation of monthly orders was completed	F 281		

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for Resident #12 for March 2015.

2. The facility staff failed to accurately transcribe orders for Seroquel (*an antipsychotic medication) in August 2015 and September 2015 during the recapitulation of monthly orders for Resident #2.

3. The facility staff failed to transcribe verbal orders and to record medication administration on the MAR (medication administration record) on 10/4/15 for Resident #27.

4. The facility staff signed off as having given treatment for a pressure ulcer for Resident #6 on 10/7/15. However, the treatment the nurse signed as given was not the treatment the nurse actually administered to Resident #6.

The findings include:

1. The facility staff failed to ensure the recapitulation of monthly orders was completed for Resident #12.

Resident #12 was admitted to the facility on 2/13/12 with diagnoses that included but were not limited to: depression, prostate cancer, atrial fibrillation, osteoarthritis, psychosis, dementia, post traumatic stress disorder, anemia, high blood pressure, dysphagia and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/25/15, coded the resident as being severely impaired to

F 281

F 281 (E):

1. Resident #12 and #2, the physician was contacted and the Seroquel order for both residents was clarified and there were no adverse effects for either resident. LPN # 16 is no longer employed. Resident #27, the physician was contacted and a physician's order was written. There was no adverse effect for Resident # 27.Resident #6, the physician and the responsible party were both notified. There was no adverse effect for Resident #6. Resident #6 no longer resides in the facility.

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F 281	Continued From page 58	F 281	2. Residents currently residing in the center have the potential to be effected. A review for current residents residing in the center has been completed by the DCS/Designee comparing the most current Physician's Order Set and telephone orders to the Medication Administration Record to verify that these are consistent and that physician's orders have been transcribed appropriately.	

make daily cognitive decisions. The resident was coded as requiring extensive assistance of one to two staff members for all of his activities of daily living.

The January 2015 POS (physician order summary) documented: "Quetiapine (Seroquel) (an antipsychotic medication*) 25 MG (milligrams) tablet; 1 tablet by mouth every morning for dementia with psychosis/delusions." This was scheduled for 9:00 a.m.
"Quetiapine 25 mg tablet; 2 tablets (50 mg) by mouth at bedtime for dementia with psychosis/delusions." This was scheduled for 9:00 p.m.
"Quetiapine 25 mg tablet; 1 by mouth daily at 2:00 p.m. for dementia with psychosis /delusions." This was scheduled for 2:00 p.m.

The January 2015 MAR (medication administration record) documented the resident received the above medications as ordered. Resident #12 received a total of 100 mg per day of Seroquel.

The February 2015 POS documented: "Quetiapine 25 mg tablet; 1 tablet by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. This was signed by the nurse on 1/28/15 that it was reviewed for accuracy.

A telephone order dated, 2/4/15, documented, "Clarification of Seroquel. Give 25 mg PO (by mouth) @ (at) 9 a.m., 25 mg PO @ 2 p.m. (hold if sedated) at 9 PM 50 mg PO."

The February 2015 MAR documented, "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth

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F 281	Continued From page 59	F 281	3. The Staff Development Coordinator/Designee has provided education to Licensed Staff regarding professional standards related to writing and transcribing physician's orders, following physician's orders, recapitulation of monthly orders and end of month change over, and the (6) rights of medication administration. A random weekly review will be completed by the DCS/Designee for (5) residents (5) times per week for (3) months to ensure that recapitulation of monthly orders is accurate, physician's orders have been transcribed appropriately including but not limited to physician's orders for antipsychotic medications.	

every day for dementia with psychosis." This was scheduled for 2:00 p.m. Starting on 2/5/15, this MAR documented, "Seroquel 25 mg PO Q (every) AM psychosis." This was scheduled for 9:00 a.m. Seroquel 50 mg PO Q HS (hours of sleep) psychosis." This was scheduled for 9:00 p.m. Again, after 2/4/15, the resident was receiving a total of 100 mg per day of Seroquel.

The March 2015 POS documented: "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. There were no other orders documented on the POS for additional Seroquel. This POS was not signed by a nurse as having had reviewed the medications at the end of the month change over. The physician signed the POS on 3/4/15.

The March 2015 MAR documented: "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. No other Seroquel was documented as administered.

The clinical record did not document any physician telephone orders between 2/12/15 and 4/4/15.

The April, May, June, July August, September, and October 2015 POSs and MARs documented the resident as receiving Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis. This was scheduled for 2:00 p.m.

An interview was conducted with LPN (licensed practical nurse) #8 on 10/8/15 at 11:33 a.m. regarding the process for the recapitulation of orders at the end of the month change over. LPN

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F 281	Continued From page 60 #8 stated, "The unit managers or selected nurses do the changeover. They compare the last months POS and any telephone orders that have come in during the month and update the POS, MARs and TARs (treatment administration records) as needed. The night shift does a second check when they change out the MARs on the last day of the month/first day of the month." The POS for February and March 2015 were reviewed with LPN #8. When asked what the blank under the box, "MEDS REVIEWED BY" was indicative of, LPN #8 stated, "Someone forgot to sign or it wasn't reviewed." An interview was conducted with the director of nursing (DON), ASM (administrative staff member) #2 on 10/8/15 at 1:41 p.m., regarding the monthly recapitulation of the orders at the end of the month. The DON stated, "Normally the unit managers do the monthly change over checks but we may call in extra staff to help out with that. If someone else did the checks the unit managers still have to review them too." When asked if the nurse doing the medication review should sign that they have completed the review, the DON stated, "Yes, there is a box at the bottom for the signature of the reviewing nurse." Resident #12's POS for February and March 2015 were reviewed with the DON. The error made in the reduction of the resident's Seroquel was shared. The DON had no comment. The administrator and director of nursing were made aware of the above findings on 10/8/15 at 2:01 p.m. A request was made for the policy on the recapitulation of the monthly orders. No further information was provided prior to exit. *Quetiapine tablets and extended-release	F 281	Random weekly observations will be completed by the DCS/Designee (5) times per week for (3) months to observe Licensed Staff during medication administration and treatment administration to ensure that medications and treatments are administered per physician's order and documented on the medication administration record appropriately.	

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(long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). <https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698019.html>

2. The facility staff failed to accurately transcribe orders for Seroquel (*an antipsychotic medication) in August 2015 and September 2015 for Resident #2.

Resident #2 was admitted to the facility on 5/24/12 with diagnoses including, but not limited to: Alzheimer's disease, coronary artery disease, history of a stroke and psychosis. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 7/17/15, Resident #2 was coded as having severe cognitive impairment for making daily decisions. He was coded as having received an antipsychotic medication on all seven days of the look back period.

A review of the clinical record for Resident #2 revealed the following order for Seroquel on the July 2015 physician order sheet (POS), signed by the provider on 7/8/15: "Quetiapine fumarate (generic name for Seroquel) 25 mg (milligram) tablet 1 tab (tablet) by mouth twice daily for dementia with psychosis. 9 a.m. and 2 p.m.

4. The results of the random weekly reviews as well as the random weekly observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Meeting monthly for (3) months. Revisions to the plan will be recommended by the committee as indicated necessary to sustain substantial compliance.
5. 11/10/15

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"Quetiapine fumarate 25 mg tablet 1/2 tab (12.5 mg) at bedtime for dementia with psychosis. 9 p.m." Further review revealed an additional verbal order dated and signed by the provider on 7/9/15: "Seroquel 12.5 mg po (by mouth) BID (twice a day) for psychosis. Give with 25 mg dose." A review of the MAR (medication administration record) for Resident #2 for July 2015 revealed that the Seroquel was given as ordered.

A review of the POS for August 2015, signed on 9/2/15 by the provider, revealed the following order for Seroquel: "Quetiapine fumarate 25 mg tablet 1/2 tab (12.5 mg) at bedtime for dementia with psychosis. 9 p.m." Further review revealed no evidence of orders for Seroquel at 9:00 a.m. and at 2:00 p.m. as ordered in July 2015. Review of the August 2015 MAR revealed that from 8/1/15 through 8/16/15, Resident #2 did not receive any of the twice-a-day Seroquel. Further review of the orders revealed a verbal order written and signed by the provider on 8/17/15: "Add Seroquel 12.5 mg po 9 a.m. and 1 p.m." Review of the August 2015 revealed that beginning 8/17/15, Resident #2 received Seroquel 12.5 mgs twice a day as re-ordered. Further review of the orders revealed a verbal order written and signed by the provider on 8/25/15: "Seroquel 25 mg po qhs (every evening at bedtime)." Review of the August 2015 MAR revealed this dose was administered as ordered.

A review of the POS for September 2015, signed by the provider on 9/2/15, revealed the following order for Seroquel: "Seroquel 25 mg po qhs (every evening at bedtime)." Again, the POS for September 2015 contained no evidence of orders for Seroquel at 9:00 a.m. and 1:00 p.m. as

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ordered in August 2015. Review of the MAR for September 2015 revealed that Resident #2 received the Seroquel as ordered every evening at bedtime.

On 10/8/15 at 4:40 p.m., LPN (licensed practical nurse) #11, the unit manager, was interviewed regarding these findings. She stated that an error at "changeover," the changing from one month's orders to the next, was the cause of Resident #2 not receiving the correct dosages of twice daily Seroquel in August in September. She stated that she did not see evidence of the Seroquel orders being carried over correctly from month to month on the physician order sheets. She also stated that she did not see evidence of the Seroquel orders being carried over correctly from month to month on the MARs. When asked who processes the orders at monthly changeover, she stated that either she does or the assistant director of nursing (ADON). She stated that the ADON had signed the POSs for August and September 2015, indicating that she had processed the changeover for those months. When asked what she does to ensure accuracy at changeover, she stated that she looks at three months worth of POSs and verbal orders, as well as three months worth of MARs to make sure she has all medications listed accurately on the new month's POS.

On 10/8/15 at 4:45 p.m., RN (registered nurse) #5, the ADON, was interviewed regarding these findings. She stated that she "must have just missed it." She stated that at changeover, she normally uses the chart, the new verbal orders since the last POS and the POS for the current month. She compares those by going backwards through all the verbal orders from the previous

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month, as well as using the POS from the previous month to reconcile all medication orders. She agreed that the POS for August 2015 and September 2015 for Resident #2 were not correct with regard to the twice daily Seroquel. She also agreed that Resident #2 had not received Seroquel as ordered by the physician in those months.

On 10/8/15 at 2:50 p.m., ASM (administrative staff member) #1 and ASM #2, the director of nursing, were informed of these concerns. Policies regarding following order transcription were requested.

A review of the comprehensive care plan for Resident #2 dated 4/1/14 and updated 4/27/15 revealed, in part, the following: "Medications as ordered by the physician."

No further information was provided prior to exit.

*Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). <https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698019.html>

^Elderly patients with dementia-related psychosis

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treated with antipsychotic drugs are at an increased risk of death. From the Federal Drug Administration website http://www.drugs.com/pro/seroquel.html.

In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."

3. The facility staff failed to transcribe verbal orders and to record medication administration on the MAR (medication administration record) on 10/4/15 for Resident #27.

Resident #27 was admitted to the facility on 6/9/15 and readmitted on 9/19/15 with diagnoses including, but not limited to: quadriplegia, pressure ulcers, contractures and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 9/16/15, he was coded as being moderately cognitively impaired for making daily decisions. He was coded as having received insulin injections for all seven days of the look back period.

A review of the orders for Resident #27 revealed, in part, the following: "Check blood sugar four times daily. Call MD if <60 or >400 (less than 60 or greater than 400). Novolog flex pen

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(*short-acting insulin) inject 4 units subcutaneously (under the skin) three times a day before meals - hold for blood sugar less than 200." This was written and signed on 8/27/15 by the nurse practitioner. Further review of the provider's orders for Resident #27 failed to reveal any other orders for short-acting insulin administration for Resident #27 on 10/4/15. Further review failed to reveal administration of any insulin other than the above-referenced order on 10/4/15.

A review of the clinical record for Resident #27 revealed an SBAR (situation/background/appearance/review and notify) communication form completed by LPN (licensed practical nurse) #16 on 10/4/15. Review of the narrative portion of the form revealed, in part, the following: "BS (blood sugar) was 585 at 4p (4:00 p.m.). Gave the 4 units before dinner. Per [name of nurse practitioner] give 2u (two units) more. Check in an hour. Checked @ (at) 5:30. BS 511. [Name of nurse practitioner] advised to give 12 units more, recheck 1 hour. 9p (9:00 p.m.) BS 310. Checked blood sugar again at 11 p (11:00 p.m.). 555 (blood glucose = 555). Called [name of nurse practitioner on call]. Advised to give 15 units." The narrative portion of the SBAR ended there.

Further review of the provider's orders for Resident #27 failed to reveal documentation of the above-referenced orders for short-acting insulin administration for Resident #27 (two units at 4:00 p.m., 12 units at 5:30 p.m., and 15 units at 11:00 p.m. on 10/4/15. Further review of the MAR (medication administration record) failed to reveal administration of any insulin other than the four units before dinner on 10/4/15.

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A review of the comprehensive care plan for Resident #27 dated 6/19/15 revealed, in part, the following: "Monitor for S/S (signs/symptoms) of hypo or hyperglycemia (low or high blood sugar) including changes in LOC (level of consciousness), sleepiness, fatigue/weakness. . .Blood glucose levels as ordered."

On 10/8/15 at 9:05 a.m., LPN (licensed practical nurse) #16 was interviewed regarding the above-referenced note and administration of 15 units of insulin to Resident #27. She stated that Resident #27 had recently been started on tube feedings and that his blood sugars "had been running high that day." She stated: "I know I did not document the orders or the insulin. I did not fill out a verbal order paper or put it on the MAR. To be honest, I was so concerned with treating his high blood sugar, writing things down was not a priority. I know I should have. But I didn't." When asked which type of insulin she administered at 4:00 p.m., 5:30 p.m., and 11:00 p.m. on 10/4/15, LPN #16 stated: "Short acting."

On 10/8/15 at 9:35 a.m., ASM (administrative staff member) #4, the nurse practitioner, was interviewed regarding the above concerns. She stated that she was aware that Resident #27's blood sugars had been elevated on 10/4/15 due to the initiation of tube feedings. She stated she remembered being called by LPN #16 on the night of 10/4/15, and that she remembered giving several orders for extra short-acting insulin. She stated: "When I give extra short-acting insulin, my order is always to check it again in an hour and to call me if it is above 350."

On 10/8/15 at 10:00 a.m., ASM (administrative

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staff member) #1, the administrator, LPN #8, the unit manager, and ASM #3, the corporate nurse, were interviewed regarding these concerns. ASM #1 stated: "We are aware that these orders are not recorded and that there is nothing on the MAR for them. This resident required a lot of time from this nurse. It was an oversight." When asked if the orders should have been recorded and the insulin administration documented on the MAR, ASM #1 stated, "Yes, it absolutely should have been documented."

On 10/8/15 at 2:50 p.m., RN (registered nurse) #4 was interviewed regarding transcribing verbal orders. She stated that when she receives a verbal order from a provider, she transcribes it onto a verbal order sheet, faxes it to the pharmacy and puts the order on the MAR so that it can be signed off by whomever follows the order.

On 10/8/15 at 3:00 p.m., LPN #19 was interviewed regarding assessment after administering an extra dose of short-acting insulin. She stated that she usually rechecks the blood sugar in 30 minutes just to make sure the levels are acceptable. She stated that at 30 minutes, the insulin's action should have peaked. She stated that she documents the blood sugar level and puts it on the 24 hour report so that subsequent shift nurses can see what has happened.

On 10/8/15 at 2:50 p.m., ASM #1 and ASM #2, the director of nursing, were informed of these concerns. Policies regarding verbal order transcription were requested.

A review of the facility policy entitled "Medications,

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Physician Order For" revealed, in part, the following: "A clinical nurse may take a verbal or telephone order from a physician (in accordance with state statutes). . .The order must be written immediately on the Physician/Telephone Order Sheet by the nurse taking the order. The order will be signed with the physician's name and counter-signed by the RN or LPN accepting and writing the order. . .The Physician's Order must specify the date the order was obtained, drug, dose, frequency and route of administration. The Clinical Nurse transcribes and processes the Physician's Medication Orders."

No further information was provided prior to exit.

According to Fundamentals of Nursing, Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...."

According to Fundamentals of Nursing, Lippincott Williams and Wilkins Philadelphia 2007 page 53. "Accurate documentation shows the care that you (nurses) provide meets the patient's needs and expressed wishes. It proves you are following the accepted standards of nursing care mandated by the law, your profession, and your health care facility..." and on page 93, "The medical record is the main source of information and communication among nurses, doctors, physical therapists, social workers, and caregivers. Everyone's notes and documentation is important because together they represent a complete

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picture of the patient's care."

* This information was obtained from the website: http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm ?setid=3A1E73A2-3009-40D0-876C-B4CB2BE56 FC5

4. The facility staff signed off as having given treatment for a pressure ulcer for Resident #6 on 10/7/15. However, the treatment the nurse signed as given was not the treatment the nurse actually administered to Resident #6.

Resident #6 was admitted to the facility on 11/21/14 and most recently readmitted on 12/10/14 with diagnoses including, but not limited to: arthritis, heart disease, chronic pain, major depressive disorder, diabetes and systolic heart failure. On the most recent MDS (minimum data set), a significant change assessment dated 6/26/15, Resident #6 was coded as having no cognitive impairment for making daily decisions. She was coded as having a stage three pressure ulcer**. She was coded as requiring the extensive assistance of staff for bed mobility, dressing, toileting, personal hygiene and bathing.

On 10/7/15 at 9:20 a.m., Resident #6's wound care was observed, with her permission. LPN (licensed practical nurse) #7 provided the wound care. Prior to going into the room, LPN #7 prepared the treatment to be applied to Resident #6's pressure ulcer. She squeezed three mls (milliliters) of Silvadene^ ointment into a medicine cup. Once she had removed the old dressing and cleansed Resident #6's stage three pressure ulcer on her lower middle sacrum, she applied the Silvadene cream to the wound using a sterile cotton applicator. The wound measured 1.3 cms

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(centimeters) by 1.2 cms by 0.7 cms. It was unchanged in measurements since 10/5/15. She completed the wound care by applying a sterile dressing.

A review of the physician's orders for Resident #6 revealed the following order, written on 8/10/15 by LPN #7 and signed by the provider on 9/11/15: "D/C Silvadene to lower medical sacrum. Cleanse wound to lower medial sacrum with wound cleanser. Apply Calcium Alginate AG^^, cover, and secure QD (every day) and prn (as needed)."

A review of the treatment administration record (TAR) for Resident #6 for October 2015 revealed the following entry: "Cleanse wound to lower medial sacrum with wound cleanser. Apply Calcium Alginate AG^^, cover, and secure QD (every day) and prn (as needed)." In the square designated for 10/7/15, LPN #7 had placed her initials.

A review of the comprehensive care plan for Resident #6 dated 4/1/14 and updated 7/10/15 revealed, in part, the following: "Skin/Wound. Administer medications as ordered."

On 10/7/15 at 2:25 p.m., LPN #7 was asked if she remembered what treatment she had applied earlier in the day to Resident #6's wound. She stated: "I put Silvadene on it." When asked if she knew what treatment was indicated on the most recent signed provider's order and TAR, she stated: "Silvadene. That's what I have written on my paper." When asked if she knew what treatment she had signed for Resident #6, she stated: "Silvadene." LPN #7 accompanied the surveyor to look at the current order and TAR for

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Resident #6's pressure ulcer treatment. LPN #7 stated: "Oh no. It says Calcium Alginate. But I know it's supposed to be Silvadene. [The wound doctor's] most recent progress note says Silvadene. I just need to change the TAR and write a new order for the Silvadene."

On 10/8/15 at 9:40 a.m., LPN #7 approached the surveyor and showed her the new order given by the wound doctor earlier in the morning. The order was for Silvadene to be applied to the pressure ulcer daily. When asked how she verifies what treatments she is signing off, she stated: "I usually go by what's written on my paper. I get that from the doctor's notes. I understand he wanted the Calcium Alginate. I should have been going off his order yesterday, rather than his note, I guess. I did not look at the TAR closely to see what I was signing."

On 10/8/15 at 2:50 p.m., ASM #1 and ASM #2, the director of nursing, were informed of these concerns. Policies regarding medication administration documentation were requested.

A review of the facility policy entitled "Physician Orders" contained nothing pertinent to these findings.

No further information was provided prior to exit.

*The NPUAP defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.

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**Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

^Silver sulfadiazine (Silvadene), a sulfa drug, is used to prevent and treat infections of second- and third-degree burns. It kills a wide variety of bacteria.
https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682598.html.

^^Calcium alginate dressings have been used in the treatment of pressure ulcers and leg ulcers.
http://www.ncbi.nlm.nih.gov/pubmed/1831374.

According to Fundamentals of Nursing, Lippincott Williams and Wilkins Philadelphia 2007 page 53. "Accurate documentation shows the care that you (nurses) provide meets the patient's needs and expressed wishes. It proves you are following the accepted standards of nursing care mandated by the law, your profession, and your health care facility..." and on page 93, "The medical record is the main source of information and communication among nurses, doctors, physical therapists, social workers, and caregivers. Everyone's notes and documentation is important because together they represent a complete picture of the patient's care."

F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=E	Continued From page 74 HIGHEST WELL BEING	F 309		

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care to promote a resident's highest level of well-being for four of 37 residents in the survey sample, Residents #27, #12, #5, and #15.

1. The facility staff failed to assess and monitor Resident #27 after administering insulin (*to treat diabetes) on 10/4/15.

2. The facility staff failed to ensure a gradual dose reduction of an antipsychotic medication (Seroquel) for Resident #12. Resident #12's Seroquel dosage was decreased from 100 mg (milligrams) to 25 mg, (a dose reduction of 75%), during the month of March 2015 when staff failed to ensure a recapitulation of Resident #12's monthly orders was completed.

3. For Resident #5, the facility staff failed to document a complete pain assessment, including measurable criteria (a pain scale), quality descriptors of pain, and any non-pharmacological interventions attempted, prior to the administration of pain medication on 2 occasions

1. Resident #12, the physician was contacted and the Seroquel order was clarified. There was no adverse effect for resident #12. Resident #27 continues to have blood glucose monitoring conducted. Resident #27 is assessed after insulin administration as well. There was no adverse effect to Resident # 27.
Resident #5 has had a pain assessment completed including measurable criteria/pain scale, quality descriptors of pain. Non-pharmacological interventions are attempted prior to administration of pain meds for Resident #5. Resident #5 also has pain re-assessed after administration of pain medications.
Resident #15's Optometrist Consult was rescheduled.

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F 309	Continued From page 75 in July 2015; and failed to document measurable criteria of a pain reassessment after the administration of pain medication on each of the same 2 occasions in July 2015. 4. Resident #15 was ordered an eye consult on 6/29/15 and nursing staff failed to follow the physician orders and did not obtain the consult appointments. The findings include: 1. The facility staff failed to assess and monitor Resident #27 after administering insulin (*to treat diabetes) on 10/4/15. Resident #27 was admitted to the facility on 6/9/15 and readmitted on 9/19/15 with diagnoses including, but not limited to: quadriplegia, pressure ulcers, contractures and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 9/16/15, he was coded as being moderately cognitively impaired for making daily decisions. He was coded as having received insulin injections for all seven days of the look back period. A review of the orders for Resident #27 revealed, in part, the following: "Check blood sugar four times daily. Call MD if <60 or >400 (less than 60 or greater than 400). Novolog flex pen (*short-acting insulin) inject 4 units subcutaneously (under the skin) three times a day before meals - hold for blood sugar less than 200." This was written and signed on 8/27/15 by the nurse practitioner. Further review of the provider's orders for Resident #27 failed to reveal any other orders for short-acting insulin	F 309	2. Residents residing in the center have the potential to be affected. A review will be conducted by the DCS/Designee for the following: A) Residents currently residing in the center with orders for insulin administration will have their physician's orders, medication administration record, and nurse's notes reviewed for the past 30 days to verify whether or not they were assessed after insulin administration. B) Residents currently residing in the center with physician's orders for antipsychotic medications will be reviewed for necessity of a gradual dose reduction. C) Residents currently residing in the center will have pain assessments completed and documented including measurable criteria/pain scale and quality descriptors of pain.	

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F 309	Continued From page 76 administration for Resident #27. (See F 281) A review of the clinical record for Resident #27 revealed an SBAR (situation/background/appearance/review and notify) communication form completed by LPN (licensed practical nurse) #16 on 10/4/15. Review of the narrative portion of the form revealed, in part, the following: "Checked [Resident #27's] blood sugar again at 11 p (11:00 p.m.). 555 (blood glucose = 555). Called [name of nurse practitioner on call]. Advised to give 15 units." The narrative portion of the SBAR ended there. Further review of the clinical record revealed no further assessment or monitoring of Resident #27's blood glucose levels following the administration of the 15 units of insulin until the 7:30 a.m. scheduled blood sugar check on 10/5/15. A review of the comprehensive care plan for Resident #27 dated 6/19/15 revealed, in part, the following: "Monitor for S/S (signs/symptoms) of hypo or hyperglycemia (low or high blood sugar) including changes in LOC (level of consciousness), sleepiness, fatigue/weakness. . .Blood glucose levels as ordered." On 10/8/15 at 9:05 a.m., LPN #16 was interviewed regarding the above-referenced note and administration of 15 units of insulin to Resident #27. She stated that Resident #27 had recently been started on tube feedings and that his blood sugars "had been running high that day." She stated: "When I checked his sugar at 11:00 (p.m.) it was high. I called [name of nurse practitioner] and she told me to give him another	F 309	A review of pain flow records and medication administration records will be conducted to determine whether or not non-pharmacological interventions were utilized prior to administration of pain medications as well as whether or not pain status was re-assessed after administration of pain medications. D) For residents currently residing in the center, physician's orders and progress notes for the last 30 days have been reviewed to identify residents with orders/consults including optometrist consults to ensure that the physician's order for the consult has been followed.	

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15 units of insulin, which I did. Then a new nurse came on. I told her to recheck the blood sugar in another hour. I don't know what happened after that." [NOTE: Attempts to interview the oncoming nurse during the survey were unsuccessful.] When asked which type of insulin she administered at 11:00 p.m. on 10/4/15, LPN #16 stated: "Short acting." When asked if she could locate any evidence that Resident #27's blood sugar had been monitored after 11:00 p.m. on 10/4/15, LPN #16 stated: "No."

On 10/8/15 at 9:35 a.m., ASM (administrative staff member) #4, the nurse practitioner, was interviewed regarding the above concerns. She stated that she was aware that Resident #27's blood sugars had been elevated on 10/4/15 due to the initiation of tube feedings. She stated she remembered being called by LPN #16 on the night of 10/4/15, and that she remembered giving several orders for extra short-acting insulin. She stated: "When I give extra short-acting insulin, my order is always to check it again in an hour and to call me if it is above 350." She stated that she did not remember getting a call after 11:00 p.m. on 10/4/15.

On 10/8/15 at 10:00 a.m., ASM (administrative staff member) #1, the administrator, LPN #8, the unit manager, and ASM #3, the corporate nurse, were interviewed regarding evidence of assessment and monitoring of Resident #27 after 11:00 p.m. on 10/4/15. ASM #1 stated: "We don't see any evidence in the chart. Will you allow us to look for the 24 hour reports?" When LPN #8 returned with the 24 hour reports for 10/4/15 and 10/5/15, he stated: "No. There is nothing here to indicate that the resident was assessed."

F 309

3. The Staff Development Coordinator/Designee has educated Licensed Nursing Staff regarding A) assessing residents after insulin administration B) completing gradual dose reductions for residents receiving antipsychotic medications C) completion of pain assessments including measurable criteria/pain scale utilization, quality descriptors, documentation of non-pharmacological interventions prior to administration of pain medications, re-assessment of pain status after administration of pain medication and D) following physicians orders for consults. A random weekly review will be conducted by the DCS/Designee for (5) residents per week to ensure that A) residents are assessed after insulin administration, B) residents with physician's orders for antipsychotic medications have

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On 10/8/15 at 2:40 p.m., LPN #10 was interviewed regarding assessment after administering an extra dose of short-acting insulin. She stated that she waits 15 minutes, then rechecks the blood sugar. She stated that she follows whatever order the provider gives regarding re-checking the blood sugar if it is different than her usual 15 minute practice.

On 10/8/15 at 3:00 p.m., LPN #19 was interviewed regarding assessment after administering an extra dose of short-acting insulin. She stated that she usually rechecks the blood sugar in 30 minutes just to make sure the levels are acceptable. She stated that at 30 minutes, the insulin's action should have peaked. She stated that she documents the blood sugar level and puts it on the 24 hour report so that subsequent shift nurses can see what has happened.

On 10/8/15 at 2:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were informed of these concerns. Policies regarding assessment and monitoring of residents receiving insulin were requested.

A review of the facility policy entitled "Insulin Administration" revealed nothing pertinent to these findings.

No further information was provided prior to exit.

*From the National Institutes of Health website http://www.nlm.nih.gov/medlineplus/.

Potter and Perry's Fundamentals of Nursing, 7th

gradual dose reductions completed, C) pain assessments are completed included including measurable criteria/pain scale, quality descriptors, utilization and documentation of non-pharmacological interventions prior to administration of pain medications, and re-assessment and documentation of pain status after pain medication administration, and D) residents with physician's orders for consults have the consultation carried out.

4. Results of the random weekly reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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edition, documents the following information on page 245: "Nursing assessment involves the collection and verification of data and the analysis of al data to establish a database about a client's perceived needs, health problems and responses to those health problems."
According to the American Diabetes Association, they describe, Insulin as "potentially one of the most dangerous medications that a medication technician/nurse will administer. Residents require sliding scale insulin to help control blood sugar levels. If too much insulin is administered, a resident's blood sugar can fall too low. If not enough insulin is administered, the blood sugar can remain too high."

2. The facility staff failed to ensure a gradual dose reduction of an antipsychotic medication (Seroquel) for Resident #12. Resident #12's Seroquel dosage was decreased from 100 mg (milligrams) to 25 mg, (a dose reduction of 75%), during the month of March 2015 when staff failed to ensure a recapitulation of Resident #12's monthly orders was completed.

Resident #12 was admitted to the facility on 2/13/12 with diagnoses that included but were not limited to: depression, prostate cancer, atrial fibrillation, osteoarthritis, psychosis, dementia, post traumatic stress disorder, anemia, high blood pressure, dysphagia and chronic obstructive pulmonary disease.

The most recent MDS assessment, a quarterly assessment, with an ARD of 9/25/15, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one to two staff members for all of his activities of daily living.

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The January 2015 POS (physician order summary) documented: "Quetiapine (Seroquel) (an antipsychotic medication*) 25 MG (milligrams) tablet; 1 tablet by mouth every morning for dementia with psychosis/delusions." This was scheduled for 9:00 a.m.
"Quetiapine 25 mg tablet; 2 tablets (50 mg) by mouth at bedtime for dementia with psychosis/delusions." This was scheduled for 9:00 p.m.
"Quetiapine 25 mg tablet; 1 by mouth daily at 2:00 p.m. for dementia with psychosis /delusions." This was scheduled for 2:00 p.m.

The January 2015 MAR (medication administration record) documented the resident received the above medications as ordered. Resident #12 received a total of 100 mg per day of Seroquel.

The February 2015 POS documented: "Quetiapine 25 mg tablet; 1 tablet by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. This was signed by the nurse on 1/28/15 that it was reviewed for accuracy.

A telephone order dated, 2/4/15, documented, "Clarification of Seroquel. Give 25 mg PO (by mouth) @ (at) 9 a.m., 25 mg PO @ 2 p.m. (hold if sedated) at 9 PM 50 mg PO."

The February 2015 MAR documented, "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. Starting on 2/5/15, this MAR documented, "Seroquel 25 mg PO Q (every) AM psychosis." This was scheduled for

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9:00 a.m. Seroquel 50 mg PO Q HS (hours of sleep) psychosis." This was scheduled for 9:00 p.m. Again, after 2/4/15, the resident was receiving a total of 100 mg per day of Seroquel.

The March 2015 POS documented: "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. There were no other orders documented on the POS for additional Seroquel. This POS was not signed by a nurse having had reviewed the medications at the end of the month change over. The physician signed the POS on 3/4/15.

The March 2015 MAR documented: "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. No other Seroquel was documented as administered.

The clinical record did not document any physician telephone orders between 2/12/15 and 4/4/15.

The April, May, June, July August, September, and October 2015 POSs and MARs documented the resident as receiving Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis. This was scheduled for 2:00 p.m.

The comprehensive care plan dated, 7/2/15, documented, "Problem: Behavior Mood - psychoactive medication." The "Approaches & Interventions" documented in part, Medication as ordered. Non-drug interventions. Monitor behavioral symptoms and side effects. Dose reduction attempts per evaluation if clinically indicated. Evaluate medication use and

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resident's response quarterly."

An interview was conducted with LPN (licensed practical nurse) #8 on 10/8/15 at 11:33 a.m. regarding the process for the recapitulation of orders at the end of the month change over. LPN #8 stated, "The unit managers or selected nurses do the changeover. They compare the last months POS and any telephone orders that have come in during the month and update the POS, MARs and TARs (treatment administration records) as needed. The night shift does a second check when the change out the MARs on the last day of the month/first day of the month." The POS for February and March 2015 were reviewed with LPN #8. When asked what the blank under the box, "MEDS (medications) REVIEWED BY" was indicative of, LPN #8 stated, "Someone forgot to sign or it wasn't reviewed."

An interview was conducted with administrative staff member (ASM) #4, the nurse practitioner, on 10/8/15 at 11:53 a.m. When asked if Seroquel is a drug that can be stopped suddenly, ASM #4 stated, "No, it should be tapered down." When asked if a resident's dose should be cut by 75%, ASM #4 stated, "No, that is not a preferred reduction." When asked what symptoms would present if a resident's Seroquel dose was decreased by 75% from their usual dose, ASM #4 stated, "There would be a dramatic change in mood, affect, insomnia and agitation." The above dose reduction from the error in the monthly changeover was shared with ASM #4. ASM #4 stated, "Well, this explains a lot. He was doing so well before and we have seen an increase in his behaviors." When asked if she personally saw his behaviors, ASM #4 stated, "Yes, I have sat here (at nurse's station) and watched him fight with

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An interview was conducted with other staff member (OSM) #22, the pharmacist, on 10/8/15 at 1:29 p.m. When asked if Seroquel can be stopped, OSM #22 stated, "It's not black and white but usually it is seen tapered." When asked if it's acceptable to go from 100 mg per day to 25 mg per day, OSM #22 stated, "Again, it's not black and white but the suggested way is to taper the dose to the most effective dose to treat what is being treated." When asked if there is any harm to the resident when a dose is dropped by 75%, OSM #22 stated, "No real harm but you need to protect them from rebound in their behaviors." OSM #22 was informed of the dose reduction for Resident #12 as documented above. OSM #22 was asked if there was any discrepancy identified or documented in the pharmacy related to the orders and the dose reduction revealed to him. No call back or additional information was received from the pharmacist prior to exit.

An interview was conducted with the director of nursing (DON) on 10/8/15 at 1:41 p.m. When asked to explain the monthly recapitulation of the orders at the end of the month, the DON stated, "Normally the unit managers do the monthly change over checks but we may call in extra staff to help out with that. If someone else did the checks the unit managers still have to review them too." When asked if the nurse doing the medication review should sign that they've done the review, the DON stated, "Yes, there is a box at the bottom for the signature of the reviewing nurse." The POS for February and March 2015

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were reviewed with the DON. The error made in the reduction of the resident's Seroquel was shared at this time. The DON had no comment.

The administrator and director of nursing were made aware of the above findings on 10/8/15 at 2:01 p.m. A request was made for the policy on the recapitulation of the monthly orders. A policy on following physician orders was also requested. A copy of all Behavior monitoring documentation from January 2015 through March 2015 was requested.

The "Behavior Symptom Monitoring Flow Records" for January, February and March 2015 were reviewed. The documented "Behavior" for January documented, "A. Delusional. B. Refusing Care. C. Yelling Out." There were no documented behaviors for January. The February "Behavior Symptom Monitoring Flow Record" documented the resident's behaviors as: A. Refusing Care. B. Screaming/yelling out. C. Uncooperative." There were no documented behaviors for the month of February. The March "Behavior Symptom Monitoring Flow Record" documented the resident's behaviors as the following: A. Refusing Care. B. Screaming. C. Yelling. D. Uncooperative." There were five documented times the resident exhibited two or more of the documented behaviors during March.

The facility policy, "Medications, Physician Order for, documented, "Policy: It is the policy of The Company that a physician's order will be obtained before medications can be administered to a resident.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby,

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Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

No further information was provided prior to exit.
* This information was obtained from the website :<https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698019.html>

3. For Resident #5, the facility staff failed to document a complete pain assessment, including measurable criteria (a pain scale), quality descriptors of pain, and any non-pharmacological interventions attempted, prior to the administration of pain medication on 2 occasions in July 2015; and failed to document measurable criteria of a pain reassessment after the administration of pain medication on each of the same 2 occasions in July 2015.

Resident #5 was admitted to the facility on 5/13/14 with the diagnoses of but not limited to multiple sclerosis, encephalopathy, depression, bipolar, anxiety and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/8/15. The resident was coded as being mildly cognitively impaired in ability to make daily life decisions, scoring an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for dressing and hygiene; limited assistance for transfers; supervision for eating; and was incontinent of bowel and bladder.

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A review of the POS (Physician's Order Sheet) for September 2015 revealed an order dated 7/9/13 for "Diclofenac* (an NSAID used to treat pain)....50 mg (milligrams)....1 tab by mouth three times daily as needed for pain" and an order dated 10/12/14 for "Hydrocodone-Acetaminophen** 5 mg-325 mg...1 tab by mouth every 4 hours as needed for pain..."

A review of the MAR (Medication Administration Record) for July 2015 revealed the following:

On 7/4/15 the resident received the Diclofenac. On the back there was no documentation for the administration of this medication, including location of pain, type of pain, pain scale, non-pharmacological interventions attempted, and a post-administration follow up assessment.

On 7/6/15 the resident received the Hydrocodone-Acetaminophen. On the back was documented "leg pain 8/10." No further assessment information was documented (type of pain, non-pharmacological interventions attempted, and a post-administration follow up assessment.) Further review of the clinical record failed to evidence any additional documentation of the administration of these pain medications in the nurse's notes.

On 10/7/15 at 4:45 p.m., an interview was conducted with LPN #10. She stated that a full pain assessment, including what type of pain, location of pain, a pain scale, non-pharmacological interventions, and a follow up assessment should be documented.

A review of the facility document, "Pain Management" documented, "Process: Perform a

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pain assessment...Whenever possible, obtain all information from the resident....Evaluate possible environmental, positional or other causes of pain (i.e., cold, temperatures, annoying noises, or uncomfortable position)....Use a pain scale when the resident describes his or her pain and amount of pain relief. A pain scale of 0 to 10 can be used with residents who can understand this concept....Reassess and document the resident's pain using an appropriate pain scale...The completed pain assessment tool is placed in the medical record...."

A review of the resident's care plan revealed one for "Pain/Comfort" undated, but contained a target date of 5/18/15, documented, "Monitor pain characteristics....quality (e.g. sharp, burning); severity (1 to 10 scale); Anatomical location; Onset; Duration (e.g. continuous, intermittent); Aggravating factors; Relieving factors...Evaluate the effectiveness of pain interventions PRN..."

On 10/7/15 at 5:30 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided by the end of the survey.

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain

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Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management.

*Information obtained from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009918/?report=details
**Information obtained from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/

4. Resident #15 was ordered an eye consult on 6/29/15, and the nursing staff failed to follow the physician orders and did not obtain the consult appointments.

Resident #15 was admitted to the facility on 4/24/15 with the following diagnoses: alcoholic cirrhosis of the liver, COPD (chronic obstructive pulmonary disease), dementia, neuropathy, hypertension, HIV (human immunodeficiency

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virus), depression and anemia (a low red blood cell count).

The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 8/1/15. Resident # 15 was coded as scoring five out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #15's clinical record revealed, in part, the following physician order: "Date: 6/29/15. Order: Eye consult ASAP (as soon as possible). Indication/Dx (diagnosis): Vision changes in HIV Dx." Signed by the nurse practitioner on 6/29/15.

Further review of the clinical record did not reveal any physician notes or nurse's notes related to an eye consult or that Resident #19 had received an eye consult as ordered.

An interview was conducted on 10/7/15 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked about the eye consult ordered for Resident #15 on 6/29/15. ASM #2 stated, "It was not done, I can't find it. We are checking with social services and the eye clinic to see if it was done and just not documented, but we can't find anything." ASM #2 was asked to describe the process that nursing staff used to obtain a consult. ASM #2 stated, "The scheduler (OSM (other staff member) #7, the unit clerk) schedules the consult appointment. In the mornings at morning meeting we review who's going out that day. We review all orders in the morning meeting to ensure that orders are not

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missed, and we follow up."

An interview was conducted on 10/7/15 at 4:45 p.m. with LPN (licensed practical nurse) #13. LPN #13 was asked to describe the process for obtaining a consult when ordered by a physician. LPN #13 responded, "We determine if there is a preference for the consulting physician/service, we tell the resident, notify the family, write/transcribe the order, fax it to the pharmacy and write a note. The order is given to (name of OSM #7) the unit clerk, and she sets up all appointments, and then once the appointment is made she (OSM #7) lets us know."

An interview was conducted on 10/7/15 at 5:10 p.m. with LPN #10. LPN #10 was asked her process for obtaining a consult when ordered by the physician. LPN #10 responded, "We write it on the 24 hour report, make a note in the nursing progress notes, and put the consult into the transportation book. (Name of OSM #7) gets the transportation book and makes the appointment; once the appointment is made she (OSM #7) will complete the appointment information. On the day of the appointment she (OSM #7) provides all the information for the resident to take to the consulting physician.

On 10/7/15 at 5:55 p.m. an interview was conducted with OSM #7. OSM #7 was asked to describe the process to set up a consult appointment. OSM #7 responded, "If someone on the unit has an appointment the nurse puts the new order into the transport book or provides me with a copy of the order. I obtain a copy of the resident's face sheet. If the doctor has not specified a consultant I try to pick one close by then set the appointment." OSM #7 was asked

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specifically about Resident #15's eye appointment. OSM #7 stated, I did not get the order and it was not put into the transportation book, so it was not done."

A review of the facility policy titled, "Policies and Procedures. Subject: Physician Orders" revealed, in part, the following documentation: "Policy: A clinical nurse shall transcribe and review all physician orders in order to effect their implementation."

On 10/7/15 at 6:15 p.m. an end of day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate clinical nurse. The administrative staff in attendance were made aware of the above findings and a request was made to provide evidence that the eye consult appointment was made for Resident #15.

On 10/8/15 at 1:30 p.m. a meeting was held with ASM #1, the administrator. ASM #1 stated, "We did not get the eye clinic appointment for Resident #15. We just didn't do it."

No further information was provided prior to the end of the survey.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419 "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

F 314 483.25(c) TREATMENT/SVCS TO — F 314

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F 314 SS=D	Continued From page 92 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer the correct treatment for a pressure ulcer* for one of 37 residents in the survey sample, Resident #6. The facility nurse administered the wrong treatment for Resident #6's pressure ulcer on 10/7/15. The findings include: Resident #6 was admitted to the facility on 11/21/14 and most recently readmitted on 12/10/14 with diagnoses including, but not limited to: arthritis, heart disease, chronic pain, major depressive disorder, diabetes and systolic heart failure. On the most recent MDS (minimum data set), a significant change assessment dated 6/26/15, Resident #6 was coded as having no cognitive impairment for making daily decisions. She was coded as having a stage three pressure ulcer**. She was coded as requiring the	F 314	F314 (D): 1. Resident #6 wound treatment was changed during survey to follow physicians order. For Resident #6, the physician and the responsible party were notified. There was no adverse effect for Resident #6. 2. Residents currently residing in the center with physician's orders for treatment administration to pressure ulcers have the potential to be affected. A review has been conducted by the DCS/Designee for residents with physician's orders for treatments to pressure ulcers to ensure that physician's orders are consistent with the treatment administration record.	

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F 314	Continued From page 93	F 314	3. Education has been provided to current Licensed Nurses by the DCS/Designee regarding following physician's orders for treatment administration. Random weekly observations will be completed by the DCS/Designee (5) times per week for (3) months to observe Licensed Staff during treatment administration to ensure that treatments are administered per physician's order and documented on the treatment administration record appropriately.	

extensive assistance of staff for bed mobility, dressing, toileting, personal hygiene and bathing.

On 10/7/15 at 9:20 a.m., Resident #6's wound care was observed, with her permission. LPN (licensed practical nurse) #7 provided the wound care. Prior to going into the room, LPN #7 prepared the treatment to be applied to Resident #6's pressure ulcer. She squeezed three mls (milliliters) of Silvadene^ ointment into a medicine cup. Once she had removed the old dressing and cleansed Resident #6's stage three pressure ulcer on her lower middle sacrum, she applied the Silvadene cream to the wound using a sterile cotton applicator. The wound measured 1.3 cms (centimeters) by 1.2 cms by 0.7 cms. It was unchanged in measurements since 10/5/15. She completed the wound care by applying a sterile dressing.

A review of the physician's orders for Resident #6 revealed the following order, written on 8/10/15 by LPN #7 and signed by the provider on 9/11/15: "D/C Silvadene to lower medical sacrum. Cleanse wound to lower medial sacrum with wound cleanser. Apply Calcium Alginate AG^^, cover, and secure QD (daily) and prn (as needed)."

A review of the treatment administration record (TAR) for Resident #6 for October 2015 revealed the following entry: "Cleanse wound to lower medial sacrum with wound cleanser. Apply Calcium Alginate AG^^, cover, and secure QD (daily) and prn (as needed)." In the square designated for 10/7/15, LPN #7 had placed her initials.

A review of the comprehensive care plan for

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F 314	Continued From page 94 Resident #6 dated 4/1/14 and updated 7/10/15 revealed, in part, the following: "Skin/Wound. Administer medications as ordered." On 10/7/15 at 2:25 p.m., LPN #7 was asked if she remembered what treatment she had applied earlier in the day to Resident #6's wound. She stated: "I put Silvadene on it." When asked if she knew what treatment was indicated on the most recent signed provider's order and TAR, she stated: "Silvadene. That's what I have written on my paper." LPN #7 accompanied the surveyor to look at the current order for Resident #6's pressure ulcer treatment. LPN #7 stated: "Oh no. It says Calcium Alginate. But I know it's supposed to be Silvadene. [The wound doctor's] most recent progress note says Silvadene. I just need to change the TAR and write a new order for the Silvadene." On 10/8/15 at 9:00 a.m., ASM (administrative staff member) #5, the consulting wound doctor, was interviewed regarding these concerns. When asked what treatment he intended for Resident #6 to be getting on the stage three pressure ulcer, he stated: "I had changed her treatment from Silvadene to Calcium Alginate." He stated, however, that he had neglected to make this change in his progress notes. He stated: "That was my error." He stated that he had given a new order earlier that morning (10/8/15) to change the order back to Silvadene "because the resident is non-compliant." He stated: "It's okay for her to get the Silvadene now." On 10/8/15 at 9:40 a.m., LPN #7 approached the surveyor and showed her the new order given by the wound doctor earlier in the morning. The	F 314	4. Results of the random weekly observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 11/10/2015	

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order was for Silvadene to be applied to the pressure ulcer daily. When asked how she knows what treatments to apply to a resident's pressure ulcer, she stated: "I usually go by what's written on my paper. I get that from the doctor's notes. I understand he wanted the Calcium Alginate. I should have been going off his order yesterday, rather than his note, I guess."

On 10/8/15 at 2:50 p.m., ASM (administrative staff member) #1 and ASM #2, the director of nursing, were informed of these concerns. Policies regarding following orders for administering medications as ordered were requested.

A review of the facility policy entitled "Physician Orders" contained nothing pertinent to these findings.

No further information was provided prior to exit.

*The NPUAP defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.

**Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
http://www.npuap.org/resources/educational-and-

STATEMENT OF DEF)C)ENC)ES AND PLAN OF CORRECT)ON	(X1) PROV)DER/SUPPL)ER/CL)A)DENT)F)CAT)ON NUMBER:	(X2) MULT)PLE CONSTRUCT)ON	(X3) DATE SURVEY COMPLETED
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NAME OF PROV)DER OR SUPPL)ER	STREET ADDRESS, C)TY, STATE, Z)P CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4))D PREF)X TAG	SUMMARY STATEMENT OF DEF)C)ENC)ES (EACH DEF)C)ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC)DENT)FY)NG)NFORMAT)ON)	)D PREF)X TAG	PROV)DER'S PLAN OF CORRECT)ON (EACH CORRECT)VE ACT)ON SHOULD BE CROSS-REFERENCED TO THE APPROPR)ATE DEF)C)ENCY)	)X5) COMPLETION OATE

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clinical-resources/npuap-pressure-ulcer-stagescategories/

^Silver sulfadiazine (Silvadene), a sulfa drug, is used to prevent and treat infections of second- and third-degree burns. It kills a wide variety of bacteria. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682598.html.

^^Calcium alginate dressings have been used in the treatment of pressure ulcers and leg ulcers. http://www.ncbi.nlm.nih.gov/pubmed/1831374.

In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

F 314

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to

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implement interventions to prevent risk of injury for two of 37 residents in the survey sample, Residents #11 and #37.

1.a. The facility staff failed to implement interventions to prevent future falls after Resident #11 fell on 9/10/15.

1.b. Resident #11 had a history of hitting his lap tray. The facility staff failed to evaluate the lap tray and Resident #11's behavior in relation to safety and potential for injury.

2. Facility staff failed to ensure the wooden covering over the bathtub in Resident # 37 bathroom was free of sharp edges.

The findings include:

1.a. The facility staff failed to implement interventions to prevent future falls after Resident #11 fell on 9/10/15.

Resident #11 was admitted to the facility on 5/2/13 with diagnoses that included but were not limited to: dementia (a brain disease) and convulsions. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/12/15, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #11 as being totally dependent with bed mobility, transfers, locomotion, dressing and toilet use. Section J documented Resident #11 as not sustaining any falls since the prior assessment. Section P "Physical Restraints" coded the resident as using a chair that prevents rising on a daily basis.

F 323 (D):

1. Resident #11 has had fall interventions implemented. Resident #11 no longer has a lap-tray, which has been discontinued. The responsible party and the physician have been notified. The care plan for Resident #11 has been updated. Resident #37, the plywood covering the resident's bathtub was replaced.

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Review of Resident #11's clinical record revealed a nurse's progress note dated 9/10/15 that documented, "Resident had a fall from bed to fall mat beside bed. Bed was in the lowest position. No bruising or injuries noted. ROM (Range of Motion) WNL (Within Normal Limits) for resident, Neuro (neurological) checks initiated. RP (Responsible Party) and MD (medical doctor) made aware." The note failed to document any interventions that were implemented to prevent future falls.

A fall investigation dated 9/10/15 documented, "Resident was laying on the fall mat beside his bed. Resident was holding on to side rail. The fall occurred 10:30 a.m., no injuries noted ROM is normal range for resident. Neuro checks initiated. No changes noted in mental status. RP and MD made aware. Bed was in lowest position." The fall investigation further documented, "Resolution/Intervention for minimizing future occurrences: _____ " The line beside this was blank. Also, a space at the bottom of the page documented, "Reviewed By: DCS (Director of Clinical Services)/ Designee: _____ Date: _____ " The lines were not signed or dated.

On 10/8/15 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #11, the unit manager responsible for Resident #11's unit. LPN #11 stated Resident #11 had a low bed and fall mats but staff was trying to get away from the use of alarms. LPN #11 stated the resident had previously been on 15 minute checks but could not state when. When asked, LPN #11 confirmed all of the above interventions were implemented prior to Resident #11's fall on 9/10/15. LPN #11 stated the resident scoots

2. Residents currently residing in the center that experience falls have the potential to be affected. Residents experiencing falls for the previous 30 days have been reviewed to ensure that they have fall interventions implemented appropriately. Residents with private bathrooms have the potential to be affected. The Maintenance Director/Designee has made environmental rounds and conducted observations to ensure that there are no further sharp edges in resident bathrooms.

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F 323	Continued From page 99	F 323	3. The Staff Development Coordinator/Designee has provided education to current staff regarding implementation of fall interventions, routine evaluation of restraints, evaluation of behaviors that could contribute to falls, and identification of concerns that are potential environmental safety hazards. The Administrator/Designee will conduct observations for (5) residents (5) times per week for (3) months to ensure that residents that have experienced falls have interventions implemented. The Administrator/Designee will also observe for and identify potential safety hazards that require correction including wooden coverings over the bathtub that may have sharp edges.	

himself out of bed and sits on the mat. When asked the facility process regarding fall prevention (after a fall has occurred), LPN #11 stated, "Afterwards (after a fall), we need to put interventions in place. She (the nurse caring for Resident #11 on 9/10/15) should have put something into place." LPN #11 confirmed nothing was implemented to prevent future falls after Resident #11 fell on 9/10/15. LPN #11 stated staff has fall meetings and to let her see what was written at that meeting.

On 10/8/15 at 11:35 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing and LPN #11. LPN #11 stated, "We discussed it (Resident #11's 9/10/15 fall) as a behavior because it's on his care plan that the resident sits on the floor."

Resident #11's safety care plan implemented on 1/23/15 documented, "Place self on floor." The care plan failed to document any information related to the date of 9/10/15.

On 10/8/15 at 12:00 p.m., the administrator and director of nursing were made aware of the above findings.

The facility policy titled, "Accident and Incident Investigation" failed to document any pertinent information regarding the above findings.

No further information was presented prior to exit.

1.b. Resident #11 had a history of hitting his lap tray. The facility staff failed to evaluate the lap tray and Resident #11's behavior in relation to safety and potential for injury.

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F 323	Continued From page 100 On 10/7/15 from 1:40 p.m. to 2:00 p.m., Resident #11 was observed in the bedroom, in a Geri chair with a full lap tray extending from one armrest to the other armrest. The lap tray was approximately 27 inches long, 15 inches wide and 2 inches in depth. The tray was constructed of hollowed hard plastic. During this time, Resident #11 was repeatedly hitting the lap tray with his hand and arm. The resident could be heard hitting the lap tray approximately 32 feet down the hall. Resident #11's comprehensive care plan with an implementation date of 1/23/15 documented in part, "Safety: Lap tray to gerichair while up in chair for safety R/T (related to) Falls- Release lap tray for ADL's (Activities of Daily Living) & rounds (Q [every] 2 hr [hours] & PRN [as needed])...Psychosocial Well being: Disruptive Behavior (specify): Bangs on table top...Behavior/Mood: Hits lap tray repeatedly..." The care plan failed to document any interventions that were implemented to ensure Resident #11 did not sustain an injury while hitting the lap tray. The safety care plan documented, "Geri gloves or protective sleeves as needed." During the survey, Resident #11 was not observed with Geri gloves or protective sleeves. On 10/8/15 at 7:35 a.m., an interview was conducted with LPN (licensed practical nurse) #11, the unit manager responsible for Resident #11's unit. LPN #11 confirmed the resident bangs on his lap tray. When asked if anyone had evaluated Resident #11's lap tray for safety and potential for injury related to the resident hitting the tray, LPN #11 stated she would have to ask the director of nursing.	F 323	4. The results of the observations will be discussed by the Administrator/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 11/10/2015	

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On 10/8/15 at 9:50 a.m., an interview was conducted with OSM (other staff member) #11 (the director of rehabilitation), OSM #12 (certified occupational therapy assistant) and OSM #19 (occupational therapist). OSM #19 stated she had seen Resident #11 bang on his lap tray then reach out like he was seeking attention. OSM #19 stated she had not received a referral to evaluate Resident #11's lap tray for safety.

On 10/8/15 at 11:35 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing) and LPN #11. LPN #11 stated she had no further information regarding Resident #11's lap tray.

On 10/8/15 at 2:00 p.m., LPN #11 was interviewed regarding Geri gloves/protective sleeves for Resident #11. LPN #11 stated Geri gloves/protective sleeves were used to protect the resident's arms and hands from getting caught on the wheelchair. LPN #11 stated Resident #11 no longer wore Geri gloves or protective sleeves because he had not recently sustained any skin tears. LPN #11 stated she could not recall the date when Resident #11's Geri gloves/protective sleeves were removed.

Review of nurse's notes from January 2015 through October 2015 failed to reveal documentation of Resident #11 sustaining any injuries to his arms or hands.

On 10/8/15 at 12:00 p.m., the administrator and director of nursing were made aware of the above findings.

The facility policy titled, "Resident Safety" documented, "Policy: A resident safety program is

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established. There is a periodic review of the program. Procedure: Periodically the resident safety program will be reviewed utilizing the Action Sheet and the Compliance worksheet. Adherence to the program will be communicated to the Executive Director and the Safety Committee..."

No further information was presented prior to exit.

2. Facility staff failed to ensure the wooden covering over the bathtub in Resident # 37 bathroom was free of sharp edges.
Resident #37 was admitted to the facility on 9/1/15 with diagnoses that included but were not limited to: dementia (a group of symptoms caused by disorders that affect the brain), hypertension (high blood pressure), gastroesophageal reflux disease (stomach contents to leak back, or reflux, into the esophagus and irritate it), hypothyroidism (not enough thyroid hormone to meet your body's needs) and encephalopathy (a term that means brain disease, damage, or malfunction).
Resident #37's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/8/15, coded the resident as being severely impaired of cognition, scoring a 5 (five) out of a possible 15 on the BIMS (Brief Interview for Mental Status) interview. Resident # 37 was coded as requiring supervision to limited assistance of one staff member for all activities of daily living. Resident # 37 was coded as being independent with transfers and ambulation.
Observations of Resident # 37's bathroom on 10/6/15 at approximately 2:00 p.m., 10/7/15 at approximately 8:10 a.m. and 10/8/15 at approximately 8:15 a.m. revealed a piece of

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plywood covering and fastened over the bathtub with un-sanded and sharp edges on the exterior edge.
On 10/8/15 at 9:15 a.m., an observation of Resident # 37's bathroom was conducted with OSM (other staff member) # 9 director of environmental services. OSM #9 was asked to inspect and feel the wooden edge of the plywood that was fastened over the bathtub. OSM # 9 acknowledged that the edge of the wood was unfinished and was sharp and could injure a resident. OSM # 9 stated. "The plywood over the tub should be replaced to eliminate the sharp edge."
On 10/8/15 at approximately 10:10 a.m. an interview was conducted with OSM # 9 regarding general repairs within the facility by the maintenance department. OSM # 9 was asked how the maintenance department is notified of repairs or possible hazards in the residents ' rooms. OSM # 9 stated, "We rely on the mock survey that is conducted by the facility staff every Monday to tell us what needs to be fixed in the residents rooms. Each maintenance staff is assigned to a wing of the facility and is responsible for those repairs." When asked if the maintenance department uses a work order system, OSM # 9 stated, "Each wing has a maintenance logbook and it is checked at least three times a week, it should be checked daily."
The facility's policy "Maintenance" documented in part, "The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition."
On 10/8/15 at approximately1:05 p.m. an interview was conducted with CNA (certified nursing assistant) #15. When asked if Resident # 37 walks in and out of her bathroom

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F 323	Continued From page 104 independently CNA #15 stated, "Yes." On 10/8/15 at approximately1:10 p.m. an interview was conducted with LPN (licensed practical nurse) #15. When asked if Resident # 37 walks in and out of her bathroom independently LPN # 15 stated, "Yes." The facility's policy "Maintenance" documented in part, "The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition." On 10/8/15 at approximately11:30 a.m., the Administrator was made aware of the above findings. No further information was presented prior to exit.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		

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record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, and clinical record review, facility document review, it was determined that the facility staff failed to ensure that the drug regimen for three of 37 residents in the survey sample, (Residents #19, #16 and #18), was free of unnecessary medications.

1. On 8/10/15 the nurse practitioner increased Resident #19's antipsychotic medication, Seroquel*, without evidence of increased behaviors or a consult with a psychiatrist.

2. On 7/21/15 the psychiatrist wrote an order to discontinue Resident #16's bedtime dose of Seroquel, the nursing staff continued to administer the medication.

3. The facility staff failed to identify targeted behaviors for the use of an antipsychotic medication, Seroquel, Resident #18.

The findings include:

1. On 8/10/15 the nurse practitioner increased Resident #19's antipsychotic medication, Seroquel *, without evidence of increased behaviors or a consult with a psychiatrist.

F329 (E):

1. Resident #19 received new orders to adjust antipsychotic medication. A psychiatric consult has been established for Resident #19. The Responsible Party was notified. Resident #16 is receiving medications per the physician's orders.
For Resident #16, the Responsible Party and the Physician were notified and the bedtime dose of Seroquel was discontinued.
Resident #18 no longer reside in the facility.

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F 329	Continued From page 106	F 329	2. Residents currently residing in the center that receive antipsychotic medications have the potential to be affected. A review has been conducted by the DCS/Designee for the past 30 days for residents with orders for antipsychotic medications to verify that residents that have had antipsychotic medication dosage increased have a psychiatric referral, that the physician's orders are consistent with the Medication Administration Record and residents are receiving antipsychotic medications as ordered by the physician, and that targeted behaviors have been identified for residents receiving antipsychotic medications.	

Resident #19 was admitted to the facility on 4/30/15 with a readmission on 6/18/15, with diagnoses that included, but were not limited to: epilepsy (a form of seizures), anxiety, hypertension, depression, pain and ulcer. The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 9/8/15. Resident #19 was coded as scoring two out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #19's clinical record revealed a telephone order dated on 8/10/15 and signed by ASM (administrative staff member) #4, the nurse practitioner, on 8/10/15 that documented, in part, the following: "Seroquel * (a medication used to treat schizophrenia, psychosis and depression), 12.5 mg (milligrams) po (by mouth) at noon daily. Indication: psychosis." Further review of the clinical record did not reveal a diagnosis of psychosis by Resident #19's primary care physician or a psychiatric evaluation that documented a diagnosis of psychosis.

Further review of Resident #19's quarterly MDS assessment with an ARD of 9/8/15 revealed, in part, Section E, Behaviors, Resident #19 was coded as having no behaviors during the seven day look back period. A comparative review of a quarterly MDS assessment with an ARD of 7/2/15 also revealed, in Section E, Behaviors, Resident #19 was coded as having no behaviors during the seven day look back period.

Further review of Resident #19's clinical record revealed a behavior symptom monitoring sheet

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F 329	Continued From page 107 dated August 2015 that documented, in part, the following information: "Behavior: A. Combative. B. Gets up without assistance. C. Attempts to get up. Cause/Trigger: A. Frustrated. B. Agitated. C. Agitated. Non pharmacologic Intervention: 1. Bathroom breaks 2. Redirect - snack 3. Walk resident, snack." The following dates were documented as behaviors occurring: "8/2/15 7-3 (dayshift) Behavior demonstrated: A, B, C. 8/3/15 7-3 Behavior demonstrated: B, A. 8/7/15 7-3 Behavior demonstrated: A, B, C. 8/11/15 7-3 Behavior demonstrated: A, C, B. 8/12/15 7-3 Behavior demonstrated: A, C, B." A review of the nursing notes for Resident #19 revealed, in part, the following documentation regarding behaviors: "8/2/15 - Resident attempts to get up without assistance. 8/3/15 No behavioral issues. 8/5/15 - No behaviors. 8/6/15 - No behaviors. 8/10/15 - Resident is fidgety, make negative statements and becomes combative. Notified NP (nurse practitioner) N.O. (new order) for Seroquel 12.5 mg PO daily at noon. UA (urinalysis) C&S (culture and sensitivity) obtain for lab (laboratory) in AM (morning) will continue to monitor. 8/11/15 - Resident getting up from w/c (wheelchair) without assistance becomes combative with redirection. 8/12/15 - Resident combative upon approach when redirected to sit. 8/14/15 Resident increased agitation, combative difficult to redirect." Further review of Resident #19's clinical record did not reveal an order for a consult with the psychiatrist and did not reveal a dictated note by nurse practitioner for the month of August, 2015. On 10/8/15 at 9:30 a.m. an interview was conducted with ASM #4, the nurse practitioner.	F 329	3. The Staff Development Coordinator/Designee has provided education to Licensed Staff regarding referring residents requiring increases in the dosage of their antipsychotic medication for psychiatric consult, administering medications including antipsychotic medications as ordered by the physician, and identifying and documenting targeted behaviors for residents receiving antipsychotic medications. A random weekly review/observation will be completed by the DCS/Designee for (5) residents per week for (3) months to ensure that there has been a psychiatric referral if their antipsychotic medication dosage has been increased, that the antipsychotic medication is being administered as ordered by the physician, and that targeted behaviors have been identified.	

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F 329	Continued From page 108	F 329	4. Results of the random weekly reviews/observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.	
	ASM #4 was asked about her process for adjusting anti psychotic medications for the residents in the facility. ASM #4 responded, "I do make adjustments and then have the psychiatrist come in, I order a consult if they are not already under the care of a psychiatrist." ASM #4 was asked what determines her decision to change or add an antipsychotic medication. ASM #4 responded, "If the resident is having delusions/hallucinations or demonstrating violent behavior. I ask staff about behaviors and also see myself, I like to see them (the residents) a couple of times before making a decision regarding an antipsychotic. The staff get frustrated because this is an increased workload, but I like to model approaches when dealing with increased behaviors." ASM #4 was asked how she documents her decisions, ASM #4 stated, "I dictate my notes and they are placed in the medical record, but it can take up to a month to get them in the record." ASM #4 was asked what her expectation was regarding the staff documentation, ASM #4 responded, "I expect staff to document in the progress notes and behavioral sheets, but it's not always documented about the behaviors." ASM #4 was asked whether or not Resident #19 was under psychiatric care, ASM #4 stated, "She (Resident #19) came in on an antipsychotic so she would have had a psychiatric consult, I just added a dose of the medication that she was already on." ASM #4 reviewed the chart and stated, "The psychiatrist wrote a note on 7/29/15." ASM #4 showed this surveyor a pharmacy recommendation for Resident #19 for evaluation of an anti anxiety medication, the psychiatrist wrote, "Patient is taking for seizures, not for psychiatric problems." ASM #4 was asked if there was a consult note for that date from the		5. 11/10/2015	

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psychiatrist that would evidence that Resident #19 had been seen by the psychiatrist. ASM #4 stated that there was not a dictated note for that date. ASM #4 was asked whether or not she discussed Resident #19's change in drug therapy with the psychiatrist, ASM #4 stated that she did not. ASM #4 was asked whether or not she wrote an order for a psychiatric consult following her visit on 8/10/15. ASM #4 stated, "I probably told the nurse but I didn't write an order." ASM #4 was asked what behaviors Resident #19 was having that caused her to order an increase in Seroquel, ASM #4 stated she was fighting other residents and very aggressive towards other residents. ASM #4 was asked where those behaviors were documented, ASM #4 stated she did not see any documentation, but she would have witnessed the behaviors and the nurses would have told her about them. ASM #4 was asked what Resident #19's targeted behaviors were, ASM #4 stated, "That she (Resident #19) will not attack other people."

On 10/8/15 at 10:35 a.m. an interview was conducted with LPN (licensed practical nurse) #15. LPN #15 was asked if Resident #19 was seen by a psychiatrist. LPN #15 responded, "I don't think she is seen by a psychiatrist." LPN #15 was asked whether or not Resident #19 demonstrated behaviors. LPN #15 stated, "She does try to get up without assistance and can be combative when she is redirected." LPN #15 was asked whether or not Resident #19 attacked other residents, LPN #15 responded, "No, she is never aggressive with other residents."

On 10/8/15 at approximately 11:30 a.m. an interview was conducted with LPN #9, the unit manager. LPN #9 was asked if she knew why

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Resident #19's Seroquel was increased in August. LPN #9 reviewed Resident #19's chart and stated, "She (Resident #19) gets up and down, she won't stay seated, she won't sleep and gets agitated." LPN #9 was asked whether or not she was aggressive towards other residents, LPN #9 stated, "No, she just gets agitated with us when we redirect her to sit down."

On 8/8/15 at 12:30 p.m. an interview was conducted with CNA (certified nursing assistant) #3, a direct care giver for Resident #19. CNA #3 was asked to describe Resident #19's behaviors, CNA #3 stated, "It is day by day, some days she's (Resident #19) is quiet and calm and then there are days when she is agitated." CNA #3 was asked whether or not Resident #19 attacked other residents, CNA #3 stated, "I never worry about her (Resident #19) hurting other residents, she is fine. She is sleepier lately, I think they changed her medications, but she is fine."

A review of the facility policy titled, "Psychoactive Medications" revealed, in part, the following documentation: "7. Non-pharmacological interventions will be used to avoid using psycho-pharmacologic drugs to the extent possible."

On 10/8/15 at approximately noon, ASM #4 provided a resident assessment dated 8/10/15 dictated by ASM #4, documenting, in part, the following: "She (Resident #19) has been going into other residents' rooms repeatedly over the last few weeks and is starting fights with other residents. She has been redirected many times but has been combative with staff and other residents. Psyche (sic) consult with (name of Psychiatrist). Will add 12.5 of Seroquel Q.

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(every) day because of her behaviors. May need to escalate after that period until (name of psychiatrist) can see her."

On 10/8/15 at 1:30 p.m. ASM #1, the administrator, was made aware of these findings. ASM #1 stated that she was not aware of the situation.

On 10/8/15 at 2:15 p.m. a telephone interview was conducted with ASM #7, the psychiatrist. ASM #7 was asked whether or not she had seen Resident #19, ASM #7 stated that she did not remember seeing her.

No further information was provided prior to the end of the survey.

2. On 7/21/15 the psychiatrist wrote an order to discontinue Resident #16's bedtime dose of Seroquel *, the nursing staff continued to administer the medication without an active order from 7/21/15 until 8/10/15.

Resident #16 was admitted to the facility on 3/31/08 with diagnoses that included, but were not limited to: AMS (altered mental status), dementia, anxiety, hypertension, insomnia, diverticulitis (An inflammation or infection in one or more small pouches in the digestive tract), behavior disturbance, hypothyroidism (decreased thyroid function) and hyperlipidemia (increased lipids in the blood stream).
The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 8/13/15. Resident # 16 was coded as scoring three out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns,

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indicating the resident was severely cognitively impaired.

A review of Resident #16's clinical record revealed a pharmacy consultation report dated 7/13/15 recommending that a GDR (gradual dose reduction) be considered for Seroquel* (an antipsychotic medication used to treat schizophrenia, bipolar disorder and psychosis). The following, in part, was written on the recommendation; "Physician's Response: I accept the recommendation above, please implement as written. D/C (discontinue) Seroquel 25 mg (milligrams) 1/2 po (by mouth) 12.5 mg Qhs (at bedtime)." The order was signed by the psychiatrist on 7/21/15. On the bottom corner of the pharmacy consultation report was a handwritten note that documented, "No change 2 (secondary) behaviors" signed by ASM (administrative staff member) #4, the nurse practitioner and dated 8/10/15.

A review of Resident #16's medication administration record for July 2015 revealed, in part, that Resident #16 was administered Seroquel 12.5 mg at bedtime on 7/23/15, 7/25/15, 7/26/15, 7/27/15, 7/29/15, 7/30/15 and 7/31/15. A review of Resident #16's medication administration record for August 2015 revealed, in part, that Resident #16 was administered Seroquel 12.5 mg on each evening between 8/1/15 and 8/10/15.

On 10/7/15 at 5:10 p.m. an interview was conducted with LPN (licensed practical nurse) #10. LPN #10 was asked to describe her process when she received an order to reduce an antipsychotic medication. LPN #10 stated, "We follow the normal process for new medication

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orders, send them to the pharmacy and put on the MAR (medication administration record). Then we call the MD (medical doctor) and the RP (responsible party)."

On 10/8/15 at 9:30 a.m. an interview was conducted with ASM (administrative staff member) #4, the nurse practitioner. ASM #4 was shown the pharmacy recommendation for a GDR on Resident #16 dated 7/21/15. ASM #4 stated that she did not agree with the psychiatrist's order to discontinue the dose and she cancelled the psychiatrist's order and instructed the staff to continue administering the Seroquel. ASM #4 was asked why there was such a delay, 7/21/15 to 8/10/15. ASM #4 stated, "Nursing asks me to review and approve any recommendations, they hold the recommendations until I do that. The psychiatrist comes late at night when no-one is here, she never returns my calls. She (the psychiatrist) comes and does not see the patients, just sits and writes notes and does not ask the nursing staff what is going on with the residents. She is just looking at the charts and she doesn't know the behaviors. That's why I have to taper so many antipsychotics." ASM #4 was asked what the nursing staff should do if they have concerns with a physician order. ASM #4 stated, "They should call the physician and discuss it." ASM #4 was asked whether or not as the nurse practitioner if she should also call with concerns regarding medications. ASM #4 stated, "If I don't agree with an order I call the physician." ASM #4 was asked whether or not she called regarding the order to discontinue Seroquel for Resident #16. ASM #4 responded, "When they hand you 20 recommendations in a day, you just can't do them all." ASM #4 was asked why she decided that the Seroquel should not be

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discontinued for Resident #16. ASM #4 stated, "She (Resident #16) runs into people, she is intrusive, she hits them." ASM #4 was asked where the behaviors were documented to support continued use of Seroquel, despite an order from the psychiatrist to discontinue the order. ASM #4 stated, "There are no notes."

On 10/8/15 at 10:35 a.m. an interview was conducted with LPN #15. LPN #15 was asked to describe her process when she received a new medication order on a pharmacy recommendation report. LPN #15 stated, "I transcribe the order, I act on the recommendation right away. The doctor / nurse practitioner see it the next morning after we get it. The psychiatrist usually comes in at night and she will sign off on the recommendations for antipsychotics and we give them to the doctor or nurse practitioner the next day. We act on it right away."

On 10/8/15 at 1:30 p.m. ASM #1, the administrator, was made aware of these findings. ASM #1 stated she was unaware of the situation. A request was made to speak with the psychiatrist and a policy was requested concerning GDRs.

On 10/8/15 at 2:15 p.m. a telephone interview was conducted with ASM #7, the psychiatrist. ASM #7 was asked how the facility handled the pharmacy recommendations for GDR. ASM #7 responded, "The facility places all recommendations for GDRs or antipsychotic medications into my box. Each time that I come to the facility, I go through the recommendations; I either agree or disagree and write a corresponding order on the recommendation. I leave this with the director of nursing or unit

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managers. The orders then go to the primary care physician or nurse practitioner." ASM #7 was asked about the order to discontinue Resident #16's Seroquel, ASM #7 stated that the Seroquel should have been discontinued and that she had written that order to do that. ASM #7 was asked if she was aware that the order had been changed on 8/10/15 by the nurse practitioner for Resident #16 to continue taking Seroquel. ASM #7 stated that she was not aware that her order had been changed, nobody had called her. ASM #7 further stated, "I don't want my orders changed by the nurse practitioner, she is not a certified psychiatry practitioner. If she wants to change an order then she needs to call me."

On 10/8/15 at 3:00 p.m. an interview was conducted with LPN #9, Wing 2 unit manager. LPN #9 was asked who reviews the pharmacy recommendations for GDR (gradual dose reduction). LPN #9 responded that the pharmacy recommendations go into the psychiatrist's mail box and she addresses them when she comes in. LPN #9 further stated that the psychiatrist comes to the facility every other Friday, usually after 6 p.m. in the evening. LPN #9 was asked what happened to the recommendations once they were reviewed and signed by the psychiatrist. LPN #9 stated, "The nurse practitioner and I review any orders she writes and they we determine if we agree/disagree with her order. If we disagree with the order we change the order and give to the nurses." LPN #9 was asked whether or not they would contact the psychiatrist about the order they disagreed with, LPN #9 responded, "No we do not contact the psychiatrist, I guess we should." LPN #9 was shown the order written by the psychiatrist to

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discontinue Seroquel for Resident #16, LPN #9 was asked who completed the note at the bottom of the recommendation, LPN #9 responded, "The nurse practitioner did, we didn't agree that the Seroquel should be discontinued." LPN #9 was asked whether or not they called the psychiatrist, LPN #9 stated that they didn't. LPN #9 was asked whether or not a nurse practitioner was able to change a physician order, LPN #9 stated, "I would think that the physician order would stand." LPN #9 was asked about the delay between 7/21/15 and 8/10/15. LPN #9 stated, "We didn't receive it until 8/10/15, I don't know why." LPN #9 was asked to verify that Resident #16 continued to receive the dose of Seroquel between 7/21/15 and 8/10/15 even though the psychiatrist had discontinued the medication. LPN #9 responded that Resident #16 continued to receive the medication.

No further information was provided prior to the end of survey.

* This information was obtained from the following website: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/>

3. The facility staff failed to identify targeted behaviors for the use of an antipsychotic medication, Seroquel*, for Resident #18.

Resident #18 was admitted to the facility on 9/2/15 with diagnoses that included but were not limited to: abnormal gait, osteoarthritis, high blood pressure, diabetes, cataracts, dementia with behaviors, Alzheimer's disease, depression, anxiety and urinary incontinence.

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The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 9/16/15, coded the resident as scoring a 9 out of 15 on the BIMS (brief interview for mental status) scale, indicating her as moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of his activities of daily living except eating in which he was coded as being independent after set up assistance was provided. In Section N - Medications, the resident was coded as having received seven days of an antipsychotic during the look back period.

The physician orders dated, 9/2/15, and signed by the physician on 9/2/15, documented, "Quetiapine (Seroquel) 25 mg (milligram) tab (tablet) give 3 tabs PO (by mouth) daily at bedtime. DX (diagnosis) Behaviors."

A telephone order dated, 9/3/15 documented, "Clarification order for Seroquel 25 mg PO Q (every) PM (bedtime) Give Seroquel (3) 25 mg tablets PO for dementia with psychosis and hallucinations."

The "Consent for Use of Psychoactive Medication Therapy" dated, 9/3/15, documented, "Psychotropic Medication Ordered - Seroquel 25 mg." The Condition being treated was documented as "Other - Behaviors."

The "Behavior Symptom Monitoring Flow Record" for September 2015 documented the targeted behavior as "Puts himself on the floor." The next column, "Causes/Trigger" documented, "Enjoys

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watching TV on the floor." There were no documented behaviors for the month of September.

The "Behavior Symptom Monitoring Flow Record" for October 2015 documented the targeted behavior as "Puts himself on the floor." The next column, "Causes/Trigger" documented, "Enjoys watching TV on the floor." There were no documented behaviors for the month of October.

Review of the nurse's notes from 9/3/15 through 10/8/15 did not document anything about putting himself on the floor. There were two notes; one on 9/28/15 on the day shift, that documented, "Resident up walking had to redirect to wheelchair." A second nurse's note dated, 10/5/15, documented on the evening shift, "Continuously got up out of his chair and wandered down the hall. Needed constant redirection."

The above entries were the only documentation of any behaviors for Resident #18.

An interview was conducted with LPN (licensed practical nurse) #9 on 10/8/15 at 8:36 a.m. regarding the process for when a resident is on antipsychotic medications, and what is monitored for this resident. LPN #9 stated, "We have to identify the targeted behaviors we are treating with the medication. We need to obtain a consent form from the resident or RP (responsible party). We put in place a Behavior Monitoring form on the front of the MAR (medication administration record)." When asked if "putting himself on the floor" was a targeted behavior for the use of antipsychotic medications, LPN #9 stated, "I wouldn't think so."

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An interview was conducted with the director of nursing (DON), ASM (administrative staff) #2, on 10/8/15 at 8:40 a.m., regarding the process for when a resident is on an antipsychotic medication. The DON stated, "We review all of the charts with new orders in morning meeting. All new admissions are reviewed also. We look at the GDRs (gradual dose reduction requests)." ASM #2, (the DON) was asked to review the orders and the behavior monitoring sheets for Resident #18. ASM #2 (the DON) was asked what targeted behavior the facility staff was monitoring for the use of the Seroquel, for Resident #18. The DON did not respond. When asked if "putting himself on the floor" is a targeted behavior for the use of Seroquel, the DON stated, "No, it's not." When asked again what the targeted behavior was for the use of Seroquel for Resident #18, the DON stated, "We don't have one."

An interview was conducted with administrative staff member (ASM) #4, the nurse practitioner, on 10/8/15 at 9:35 a.m. When asked what targeted behaviors would be appropriate for the use of Seroquel, ASM #4 stated, "Delusions, hallucinations, and violent behaviors against self or others." When asked if "putting himself on the floor" was a targeted behavior for the use of Seroquel, ASM #4 stated, "No, that I would not consider a targeted behavior." When asked where she sees documentation of the resident's behaviors, ASM #4 stated, "On the Behavior Monitoring sheets and the nurse's notes." When asked if she normally sees the behaviors documented, ASM #4 stated, "Not always." When asked what the targeted behaviors Resident #18 has, ASM #4 stated, "I referred him to psych

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(psychiatry) because he came in on those drugs and wanted her input."

The psychiatry consult dated, 9/4/15, documented, "Patient with problems of mood, depression, psychosis, dementia, helpless, delusional/paranoid with mood/depression....Continue Seroquel 25 mg (3) =75 mg Q (every) HS - psychosis."

The facility policy, "Psychoactive Medications" documented, "Procedure: 1. Psycho-pharmacologic drugs will be ordered only to treat the resident's medical condition with an appropriate diagnosis in accordance with acceptable standards of practice, and include periodic review for continued need, appropriate diagnosis and side effects. 2. The facility supports the goals of determining the underlying cause of resident behavioral symptoms to determine the appropriate treatment of non-pharmacological and pharmacological interventions according to acceptable standards of practice. 3. Facility will monitor psychotropic drug use for adverse effects through a multi-disciplinary approach. a. Residents receiving psychoactive medication will receive a psychoactive medication evaluation quarterly. b. AIMS (AIMS - abnormal involuntary movement scale is used as an assessment tool for tardive dyskinesia) ** will be conducted quarterly for resident receiving anti-psychotic medication. c. Resident with behaviors will be monitored using a behavior symptom flow record when behaviors are present. d. Social Services will complete a review of behaviors and mood status as part of the social services quarterly review. 4. Drug Regimen reviews will be conducted monthly by the pharmacist for unnecessary use, excessive doses or duration in

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absence of acceptable medical diagnosis according to standard of practice. Recommendations will be communicated to the attending physician with recommendations to either reduce or eliminate drug usage as appropriate....6. Residents with behaviors will be reviewed weekly by the inter-disciplinary team to identify patterns, trends, causative factors, and interventions to minimize or eliminate behaviors. Review of psychoactive medications may be included in the review. 7. Non-Pharmacological interventions will be used to avoid using psycho-pharmacologic drugs to the extent possible. 8. Interdisciplinary team should investigate the cause of the behavior and treat the cause (i.e. remove source of stimuli)."

The administrator and director of nursing were made aware of these findings on 10/8/15 at 2:01 p.m.

No further information was provided prior to exit.
*Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release

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F 329	Continued From page 122 tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a698019.html>	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the	F 334		

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influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

1. Resident #6, documentation pertaining to immunization status related to pneumonia and influenza was completed and added to the clinical record.
2. Residents currently residing in the center have the potential to be affected. A review will be completed by the DCS/Designee to ensure that the clinical record for current residents reflect immunization status related to influenza and pneumonia.

3. Education has been provided by the DCS/Designee to the current Licensed Nurses regarding providing CDC education related to pneumonia and influenza vaccinations, obtaining consents for administration of pneumonia and influenza vaccinations, administration of pneumonia and influenza vaccinations, and documentation of pneumonia and

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This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to determine immunization status and offer influenza and pneumonia vaccines to one of 37 residents in the survey sample, Resident #6.

The facility staff failed to determine Resident #6's immunization status at her admission and failed to offer pneumonia and influenza vaccines to her.

The findings include:

Resident #6 was admitted to the facility on 11/21/14 and most recently readmitted on 12/10/14 with diagnoses including, but not limited to: arthritis, heart disease, chronic pain, major depressive disorder, diabetes and systolic heart failure. On the most recent MDS (minimum data set), a significant change assessment dated 6/26/15, Resident #6 was coded as having no cognitive impairment for making daily decisions. She was coded as requiring the extensive assistance of staff for bed mobility, dressing, toileting, personal hygiene and bathing. She was coded as having received the influenza vaccine for the previous flu season outside the facility. She was coded as not having been offered the pneumonia vaccine.

A review of the clinical record for Resident #6 failed to reveal any documentation regarding her immunization status with respect to pneumonia and influenza.

On 10/7/15 at 2:30 p.m., LPN (licensed practical

influenza vaccinations in the medical record on both the immunization record as well as the Medication Administration Record. The education will also include ensuring that pneumo-vaccine status is determined upon admission and documented on the immunization record in the medical record. The DCS/Designee will conduct a review of the medical record for (5) random residents per week for (3) months to ensure that pneumo-vaccine status is established upon admission and documented on the immunization record, education was provided to the resident or RP for residents with physicians orders for the pneumonia and/or influenza vaccinations. The review will also include a review to ensure consent was obtained prior to

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nurse) #11, the unit manager, was asked to locate the above-referenced immunization status records. She stated: "There is no immunization record for her. I wasn't here [when she was admitted]. I can't say either vaccine was ever offered to her."

On 10/8/15 at 9:25 a.m., Resident #6 was interviewed regarding influenza and pneumonia vaccines offered by the facility. She stated: "I really don't remember one way or the other."

On 10/8/15 at 2:50 p.m., LPN (licensed practical nurse) #16 was interviewed regarding the process for determining immunization status and offering vaccines to a resident on admission. She stated that she looks through the hospital discharge records of a newly-admitted resident to see what she can determine. If there are no records there, she stated that she provides the resident/responsible party (RP) with education about the vaccines and gives the influenza and pneumonia vaccines if the resident/RP consents. She stated that if the resident does not consent, she documents the refusal in the nursing note and on an Immunization Record form in the chart.

On 10/8/15 at 3:50 p.m., LPN #11 was interviewed about the process for admitting nurses regarding immunization status. She stated that admitting nurse should go through the hospital discharge paperwork, and fill out the facility's Immunization Record accordingly. She stated that if there are no records to be found in the hospital paperwork, the resident/RP is interviewed. If no information is still available, the admitting nurse should offer the consent and education forms for both the pneumonia and influenza vaccines, and proceed according to the

administration of the pneumonia and/or influenza vaccination, and documentation of administration of the pneumonia and/or the influenza vaccination on both the immunization record as well as the Medication Administration Record.

4. The results of the random weekly reviews will be discussed by the DCS/Designee at the QAPI Committee monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.

5. 11/10/2015

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F 334	Continued From page 126 resident/RP's wishes. She stated that all of this should also be documented in the nurses' notes. On 10/8/15 at 2:50 p.m., ASM (administrative staff) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding immunizations on admission were requested. A review of the comprehensive care plan for Resident #6 dated 4/1/14 and updated 7/10/15 revealed nothing pertinent to these findings. A review of the facility policy entitled "Pneumonia Vaccines" revealed, in part, the following: "Residents admitted to the facility will be given the opportunity to receive the pneumococcal vaccine per physician's order. Residents will be asked if they have received either of the pneumonia vaccines." No further information was provided prior to exit.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		

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by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to act upon a pharmacy regimen review for one of 37 residents in the survey sample, Resident #12.

A. Resident #12's Seroquel dosage was decreased from 100 mg (milligrams) to 25 mg, (a dose reduction of 75%); during the month of March 2015 when staff failed to ensure a recapitulation of Resident #12's monthly orders was completed. There was no documented physician order for Resident #12's dose reduction and was not identified during the March 2015 Pharmacy Medication Regimen Review (MRR).

B. Resident #12's June 2015 Pharmacy Medication Regimen Review (MRR), recommendation for a gradual dose reduction was not acted upon for Resident #12 as evidenced by no signatures of the doctor or director of nursing.

The findings include:

A. Resident #12's Seroquel dosage was decreased from 100 mg (milligrams) to 25 mg, (a dose reduction of 75%); during the month of March 2015 when staff failed to ensure a recapitulation of Resident #12's monthly orders was completed. There was no documented physician order for Resident #12's dose reduction and was not identified during the March 2015 Pharmacy Medication Regimen Review (MRR).

Resident #12 was admitted to the facility on 2/13/12 with diagnoses that included but were not limited to: depression, prostate cancer, atrial

1. Resident #12, the Physician was contacted and the order for Seroquel has been clarified. The Responsible Party has been notified.
2. Residents currently residing in the center with physician's orders for antipsychotic medications have the potential to be affected. A review has been completed by the DCS/Designee for the past 30 days to ensure that pharmacy regimen recommendations have been reviewed by the Physician and the DCS and have been addressed.

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fibrillation, osteoarthritis, psychosis, dementia, post traumatic stress disorder, anemia, high blood pressure, dysphagia and chronic obstructive pulmonary disease.

The most recent MDS assessment, a quarterly assessment, with an ARD of 9/25/15, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one to two staff members for all of his activities of daily living.

The January 2015 POS (physician order summary) documented: "Quetiapine (Seroquel) (an antipsychotic medication*) 25 MG (milligrams) tablet; 1 tablet by mouth every morning for dementia with psychosis/delusions." This was scheduled for 9:00 a.m.
"Quetiapine 25 mg tablet; 2 tablets (50 mg) by mouth at bedtime for dementia with psychosis/delusions." This was scheduled for 9:00 p.m.
"Quetiapine 25 mg tablet; 1 by mouth daily at 2:00 p.m. for dementia with psychosis /delusions." This was scheduled for 2:00 p.m.

The January 2015 MAR (medication administration record) documented the resident received the above medications as ordered. Resident #12 received a total of 100 mg per day of Seroquel.

The February 2015 POS documented: "Quetiapine 25 mg tablet; 1 tablet by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. This was signed by the nurse on 1/28/15 that it was reviewed for accuracy.

3. Staff Development/designee has provided education to Licensed Staff regarding prompt processing and resolution of Pharmacy Medication Regimen Review (MRR). The DCS/Designee will review Pharmacy MRR's for (5) residents weekly for (3) months to ensure timely and appropriate resolution.
4. Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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A telephone order dated, 2/4/15, documented, "Clarification of Seroquel. Give 25 mg PO (by mouth) @ (at) 9 a.m., 25 mg PO @ 2 p.m. (hold if sedated) at 9 PM 50 mg PO."

The February 2015 MAR documented, "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. Starting on 2/5/15, this MAR documented, "Seroquel 25 mg PO Q (every) AM psychosis." This was scheduled for 9:00 a.m. Seroquel 50 mg PO Q HS (hours of sleep) psychosis." This was scheduled for 9:00 p.m. Again, after 2/4/15, the resident was receiving a total of 100 mg per day of Seroquel.

The March 2015 POS documented: "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. There were no other orders documented on the POS for additional Seroquel. This POS was not signed by a nurse having had reviewed the medications at the end of the month change over. The physician signed the POS on 3/4/15.

The March 2015 MAR documented: "Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis." This was scheduled for 2:00 p.m. No other Seroquel was documented as administered.

The clinical record did not document any physician telephone orders between 2/12/15 and 4/4/15. There was no documented physician order for Resident #12 to have a dose reduction in Quetiapine during the month of February or March 2015.

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The April, May, June, July August, September, and October 2015 POSs and MARs documented the resident as receiving Quetiapine 25 mg tablet; 1 tab (tablet) by mouth every day for dementia with psychosis. This was scheduled for 2:00 p.m.

Review of Resident #12's Pharmacy Medication Regimen Review (MRR), revealed there were no pharmacy recommendations for the months of March, April and May 2015. In June 2015 a gradual dose reduction was requested for the use of Quetiapine (Quetiapine 25 mg tablet).

The comprehensive care plan dated, 7/2/15, documented, "Problem: Behavior Mood - psychoactive medication." The "Approaches & Interventions" documented in part, Medication as ordered. Non-drug interventions. Monitor behavioral symptoms and side effects. Dose reduction attempts per evaluation if clinically indicated. Evaluate medication use and resident's response quarterly."

An interview was conducted with LPN (licensed practical nurse) #8 on 10/8/15 at 11:33 a.m. regarding the process for the recapitulation of orders at the end of the month change over. LPN #8 stated, "The unit managers or selected nurses do the changeover. They compare the last months POS and any telephone orders that have come in during the month and update the POS, MARs and TARs (treatment administration records) as needed. The night shift does a second check when the change out the MARs on the last day of the month/first day of the month." The POS for February and March 2015 were reviewed with LPN #8. When asked what the blank under the box, "MEDS (medications) REVIEWED BY" was indicative of, LPN #8 stated,

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"Someone forgot to sign or it wasn't reviewed."

An interview was conducted with administrative staff member (ASM) #4, the nurse practitioner, on 10/8/15 at 11:53 a.m. When asked if Seroquel is a drug that can be stopped suddenly, ASM #4 stated, "No, it should be tapered down." When asked if a resident's dose should be cut by 75%, ASM #4 stated, "No, that is not a preferred reduction." When asked what symptoms would present if a resident's Seroquel dose was decreased by 75% from their usual dose, ASM #4 stated, "There would be a dramatic change in mood, affect, insomnia and agitation." The above dose reduction from the error in the monthly changeover was shared with ASM #4. ASM #4 stated, "Well, this explains a lot. He was doing so well before and we have seen an increase in his behaviors." When asked if she personally saw his behaviors, ASM #4 stated, "Yes, I have sat here (at nurse's station) and watched him fight with another resident."

An interview was conducted with other staff member (OSM) #22, the pharmacist, on 10/8/15 at 1:29 p.m. When asked if Seroquel can be stopped, OSM #22 stated, "It's not black and white but usually it is seen tapered." When asked if it's acceptable to go from 100 mg per day to 25 mg per day, OSM #22 stated, "Again, it's not black and white but the suggested way is to taper the dose to the most effective dose to treat what is being treated." When asked if there is any harm to the resident when a dose is dropped by 75%, OSM #22 stated, "No real harm but you need to protect them from rebound in their behaviors." OSM #22 was informed of the dose reduction for Resident #12 as documented above. OSM #22 was asked if there was any

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE
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discrepancy identified or documented in the pharmacy related to the orders and the dose reduction revealed to him. No call back or additional information was received from the pharmacist prior to exit.

An interview was conducted with the director of nursing (DON) on 10/8/15 at 1:41 p.m. When asked to explain the monthly recapitulation of the orders at the end of the month, the DON stated, "Normally the unit managers do the monthly change over checks but we may call in extra staff to help out with that. If someone else did the checks the unit managers still have to review them too." When asked if the nurse doing the medication review should sign that they've done the review, the DON stated, "Yes, there is a box at the bottom for the signature of the reviewing nurse." The POS for February and March 2015 were reviewed with the DON. The error made in the reduction of the resident's Seroquel was shared at this time. The DON had no comment.

The administrator and director of nursing were made aware of the above findings on 10/8/15 at 2:01 p.m. A request was made for the policy on the recapitulation of the monthly orders. A policy on following physician orders was also requested. A copy of all Behavior monitoring documentation from January 2015 through March 2015 was requested.

The "Behavior Symptom Monitoring Flow Records" for January, February and March 2015 were reviewed. The documented "Behavior" for January documented, "A. Delusional. B. Refusing Care. C. Yelling Out." There were no documented behaviors for January. The February "Behavior

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Symptom Monitoring Flow Record" documented the resident's behaviors as: A. Refusing Care. B. Screaming/yelling out. C. Uncooperative." There were no documented behaviors for the month of February. The March "Behavior Symptom Monitoring Flow Record" documented the resident's behaviors as the following: A. Refusing Care. B. Screaming. C. Yelling. D. Uncooperative." There were five documented times the resident exhibited two or more of the documented behaviors during March.
The facility could not provide behavior monitoring sheets for April and May of 2015.

The administrative team was made aware of the above findings on 10/7/15 at 6:14 p.m.

No further information was provided prior to exit.

B. Resident #12's June 2015 Pharmacy Medication Regimen Review (MRR), recommendation for a gradual dose reduction was not acted upon for Resident #12 as evidenced by no signatures of the doctor or director of nursing.

A review of the clinical record was conducted on 10/7/15. The pharmacy medication regimen reviews (MRR) for the past year were requested. A copy of the June 2015, MMR for Resident #12, dated, 6/13/15, was received. The form documented, "(Resident #12) has received Quetiapine for behavioral or psychological symptoms of dementia ...If clinically appropriate, please evaluate for a gradual dosage reduction, with the end goal of discontinuation of therapy if possible." for Resident #12. There was no documentation on the form from the physician or director of nursing.

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An interview was conducted with LPN (licensed practical nurse) #6 on 10/7/15 at 4:16 p.m., and Resident #12's MRR for June 2015 was reviewed with LPN #6. LPN #6 was then asked if it the MMR recommendation for "considering a gradual dose reduction for Resident #12" had been addressed. LPN #6 stated, "It's not signed, and it wasn't addressed."

An interview was conducted with the director of nursing (DON) ASM (administrative staff member) #2, on 10/7/15 at 4:50 p.m. When asked what happened with Resident #12's MRR for June, the DON stated, "It wasn't acted upon." ASM #2 was then asked when action should be taken for a recommendation on the MRRs. ASM #2 (the DON) stated, "Once we receive them from the pharmacist we should get them taken care of with the physicians."

The administrative team was made aware of the above findings on 10/7/15 at 6:14 p.m.

No further information was provided prior to exit.

F 441 SS=E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -

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(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to follow infection control practices for three of 37 residents in the survey sample, Residents # 8, 11 and 7 and failed to implement infection control practices in the laundry room.

1. The facility staff failed to store nebulizer

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equipment (aerosol mask) in a manner to prevent infection for Resident #8.

2. The facility staff failed to maintain Resident #11's Geri chair armrest free from torn areas, exposing cloth and foam that was unable to be sanitized.

3. The facility staff failed to maintain infection control procedures during a dressing change for Resident #7.

4. The facility staff failed to prevent a dirty fan from blowing on clean clothes in the facility laundry room.

The findings include:

1. The facility staff failed to store nebulizer equipment (aerosol mask) in a manner to prevent infection for Resident #8.

Resident #8 was admitted to the facility on 4/4/15 and readmitted on 8/17/15 with diagnoses that included but were not limited to cerebral palsy, oropharygeal dysphagia (difficulty swallowing) with peg tube placement (percutaneous endoscopic gastrostomy tube placement, or PEG^), osteoarthritis, quadriplegia, neurogenic bladder (uncontrollable bladder due to central nervous system dysfunction) and chronic pain syndrome. Resident #8's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 9/29/15. Resident #8 was coded as being moderately cognitively impaired in the ability to make daily life decisions scoring 11 out

441 (E):

1. Resident #8, the nebulizer mask was corrected. For Resident #11, the geri chair was repaired. Resident #7's wound has healed and there was no adverse effect. The fan was removed from laundry room.
2. Residents currently residing in the center have the potential to be affected. Environmental rounds/observations have been conducted for residents with physician's orders for nebulizer's, for residents in wheelchairs and geri-chairs, and in the laundry room to identify further infection control concerns.

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of 15 on the BIMS (Brief Interview for Mental Status). Resident #8 was coded as requiring total dependence on staff with transfers, dressing, eating, toileting, and personal hygiene.

On 10/6/15 at 1:50 p.m., initial tour was conducted. At 2 p.m., Resident #8's room was observed. A nebulizer machine and tubing was observed on the bedside table. The nebulizer mask was lying face down on the table with no equipment bag. The nebulizer mask was labeled "9/23" indicating the mask had not been changed in 13 days.

On 10/6/15 at 5:15 p.m., Resident #8's room was observed. The nebulizer mask dated "9/23" was lying face down on the bedside table with no equipment bag.

On 10/7/15 at 8:23 a.m., Resident #8's room was observed. The nebulizer mask was dated "10/7" and was stored in an equipment bag.

Review of Resident #8's most recently signed physician order sheet dated 9/30/15 revealed the following active orders:

"Albuterol Sulfate 30's, U-D (unit dose), P/F 2.5 mg (milligram)/3ml (milliliter) via-neb...Inhale 1 unit dose via nebulizer every 6 hours as needed for shortness of breath/wheezing.*

"Ipratropium-albuterol UD (unit dose) 0.5-3MG/3 Ampul-NEB (nebulizer) ...every 6 hours as needed for shortness of breath/wheezing." *

Review of the September 2015 and October 2015 MAR revealed that Resident #8 had not received a nebulizer treatment between 9/23 and 10/7/15.

F 441 3. The Staff Development Coordinator/Designee has provided education to current employees regarding infection control procedures in aspects of care including storing nebulizers appropriately in an equipment bag and changing the tubing and the mask in a timely fashion. The employee education also included: A) identification of ripped or torn equipment that cannot be sanitized and the process for reporting these types of concerns, B)ensuring that infection control practices are maintained during treatment administration including sanitizing scissors prior to and after each treatment administration, C)maintaining clean linens and preventing soiled or contaminated items from coming into contact with clean linens including a dirty

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F 441	Continued From page 138 On 10/7/15 at 10:15 a.m., an interview was conducted with LPN (Licensed Practical Nurse) # 3, the nurse who was on shift 10/6/15. When asked how often nebulizer equipment should be changed she stated, "I think maybe twice a week. Night shift usually does that." When informed of the above concern and findings about Resident #8's nebulizer equipment she stated, "I think that is only an infection control issue if he was getting the nebulizer's every day. He only gets Nebs PRN (as needed)." When asked if Resident's who receive PRN nebulizers are excluded from the equipment cleaning schedule she stated she would try to find a policy on changing nebulizer equipment. According to the facility's policies and procedures, "An equipment change schedule provides a schedule for changing disposable equipment at regular intervals as determined by manufacturers recommendations and local community standards." According to facility policy titled, "Equipment Change Schedule," nebulizer set up should be changed, "Once, every (7) days along with equipment bag labeled with name, date, and room number." On 10-7-15 at p.m., administration was made aware of the above findings. No further information was presented during the time of survey. "The humidification system may be a source of bacteria. Pseudomonas aeruginosa is frequently the organism involved. Oxygen delivery equipment such as cannulas and masks can also	F 441	fan. Random weekly environmental rounds/observations will be conducted by the Administrator/Designee(s) (5) times per week for (3) months to identify infection control concerns including the appropriate storage of nebulizers in an equipment bag, identification of torn or ripped equipment that is unable to be appropriately sanitized, ensuring that infection control practices are maintained during treatment administration including sanitation of scissors prior to and after treatment administration, and to identify concerns regarding contamination of clean linen to include soiled fans blowing on clean linen.	

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F 441	Continued From page 139	F 441	4. Results of the random weekly rounds/observations will be discussed by the Administrator/DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.	

harbor organisms." (Ignatavicius, D. & Workman, L. (2002) Medical Surgical Nursing, Critical Thinking for Collaborative Care, 4thedition. (p.492) Philadelphia, Pennsylvania: W. B. Saunders Company.)

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

*According to Davis Drug Guide For Nurses, 11th edition:

Albuterol Sulfate is used as a bronchodilator to prevent reversible airway obstruction caused by asthma or COPD (Chronic Obstructive Pulmonary Disease). p.120

Ipratropium-albuterol is used as maintenance therapy of reversible airway obstruction due to COPD, including chronic bronchitis and emphysema. p. 696

^ This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/presentations/100125_5.htm

2. The facility staff failed to maintain Resident #11's Geri chair armrest free from torn areas, exposing cloth and foam that was unable to be sanitized.

Resident #11 was admitted to the facility on 5/2/13 with diagnoses that included but were not limited to: dementia (a brain disease) and convulsions. Resident #11's most recent MDS

5. 11/10/15

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(minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/12/15, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #11 as being totally dependent with bed mobility, transfers, locomotion, dressing and toilet use.

On 10/7/15 at 1:40 p.m., Resident #11 was observed in a Geri chair in the bedroom. Two torn areas (with cloth and foam exposed) were observed on the right armrest of the Geri chair. The first area was approximately one inch long by one inch wide. The second area was approximately one and a half feet long by two inches wide.

On 10/7/15 at 4:25 p.m., an interview was conducted with CNA (certified nursing assistant) #8 When asked the facility process for ensuring equipment such as wheelchair and Geri chairs are in good repair, CNA #8 stated, "If we see something, we inform maintenance and they fix it."

On 10/7/15 at 4:40 p.m., CNA #8 was shown Resident #11's Geri chair armrest. CNA #8 stated the armrest should be like the other armrest.

On 10/7/15 at 5:29 p.m., an interview was conducted with OSM (other staff member) #9, the director of maintenance. OSM #9 stated his department power washes wheelchairs and Geri chairs once a week. OSM #9 stated the wheelchairs and Geri chairs on wing one (Resident #11's wing) are washed every Monday.

On 10/7/15 at 5:55 p.m., another interview was

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conducted with OSM #9. OSM #9 stated his assistant put some new Geri chairs together and took the chairs to the therapy department on the previous Friday (10/2/15). OSM #9 stated he wasn't aware of any particular resident that needed a new Geri chair.

On 10/7/15 at 6:00 p.m., an interview was conducted with OSM #11, the director of rehabilitation. OSM #11 stated he was not recently made aware of anyone who needed a new Geri chair. OSM #11 stated no one has come to him regarding Resident #11's Geri chair armrests.

On 10/7/15 at 6:35 p.m., ASM (administrative staff member) #1, the administrator and director of nursing were made aware of the above findings. ASM #1 was asked how staff ensures torn wheelchair and Geri chair armrests are free from contamination and bacteria. ASM #1 stated, "I don't know."

The facility policy titled, "Infection Control Committee" documented in part, "Policy: The Infection Control Committee (ICC) establishes and oversees the infection control program for the facility. Procedure: 2. The objectives of the ICC will be to: b. Establish an effective facility-wide infection control program that includes the following elements: xiii. Handling, storing, processing and transporting linens, supplies and equipment that prevent the spread of infection..."
No further information was presented prior to exit.
3. The facility staff failed to maintain infection control procedures during a dressing change for Resident #7.

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Resident #7 was admitted to the facility on 11/18/14 with diagnoses that included but were not limited to: pressure ulcer, above the knee amputation, diabetes, hyperlipidemia, dementia, and high blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, coded the resident as scoring a 13/15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for bed mobility, dressing and personal hygiene. He was coded as totally dependent of one staff member for bathing and toilet use. In Section M - Skin Conditions, the resident was coded as having a stage IV pressure ulcer.

Observation was made of LPN (licensed practical nurse) #7, the wound nurse; performing Resident #7's wound care on 10/7/15 at 1:37 p.m. LPN #7 was gathering her supplies on her treatment cart for the treatment. She pulled her scissors out of her pocket and cut through a dressing package and cut the dressing (Calcium Alginate)* with her scissors.

LPN #7 proceeded to perform the dressing change. She applied the calcium alginate dressing directly on the wound bed. She then applied a dry sterile dressing.

At 1:50 p.m. LPN #7 was asked what contents were in her pocket with her scissors, LPN #7 showed the pens, markers and scissors. When asked if she cleaned the scissors prior to cutting the dressing, LPN #7 stated, "I can't remember when I used my scissors last. Nope, I didn't clean

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them prior to using them."

An interview was conducted with the ASM (administrative staff member) #2, director of nursing (DON) on 10/7/15 at 2:41 p.m. When asked if a nurse is using scissors to cut a dressing, are there any steps that should be implmented, ASM #2, (the DON) stated, "First the scissors should be cleaned with alcohol prior to using them." The above observation and concern was shared with ASM #2 (the DON). ASM #2 asked if the dressing touched the wound and was informed that the dressing cut by LPN #7, was the calcium alginate that was applied directly to the wound.

The facility policy, "Dressing Change" was reviewed. The policy did not address the cleaning of scissors prior to a dressing change.

In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick.
In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol.
Reference:

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	495362	A. BUILOING _____ B. WING _____	C 10/08/2015

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000.

The administrative team was made aware of the above findings on 10/7/15 at 6:14 p.m.

No further information was provided prior to exit.
*Highly absorbent, biodegradable alginate dressings are derived from seaweed. They have been successfully applied to cleanse a wide variety of secreting lesions. The high absorption is achieved via strong hydrophilic gel formation This limits wound secretions and minimizes bacterial contamination. Alginate fibres trapped in a wound are readily biodegraded.
Alginate dressings maintain a physiologically moist microenvironment that promotes healing and the formation of granulation tissue. Alginates can be rinsed away with saline irrigation, so removal of the dressing does not interfere with healing granulation tissue. This makes dressing changes virtually painless. Alginate dressings are very useful for moderate to heavily exudating wounds
http://www.worldwidewounds.com/1998/june/Alginates-FAQ/alginates-questions.html

4. The facility staff failed to prevent a dirty fan from blowing on clean clothes in the facility laundry room.

An observation of the facility laundry room on 10/7/15 at 1:00 p.m. revealed a floor drying fan with the discharge vent elevated off the floor blowing onto a rack of uncovered hanging clean

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clothes. Further review of the fan revealed the intake vents covered with dirt and dust and the discharge vent containing dirt and dust.

An observation of the facility laundry room on 10/7/15 at 1:40 p.m. revealed a floor drying fan with the discharge vent elevated off the floor blowing onto a rack of uncovered hanging clean clothes. Further review of the fan revealed the intake vents covered with dirt and dust and the discharge vent containing dirt and dust.

An observation of the facility laundry room on 10/7/15 at 2:30 p.m. revealed a floor drying fan with the discharge vent elevated off the floor blowing onto a rack of uncovered hanging clean clothes. Further review of the fan revealed the intake vents covered with dirt and dust and the discharge vent containing dirt and dust.

On 10/8/15 at approximately 10:05 a.m. an observation of the facility laundry room was conducted with OSM # 10 housekeeping district manager. When shown the fan that had been blowing on the rack of clean clothes, OSM # 10 stated, "It should not be blowing directly on the clean clothes." OSM # 10 acknowledged that the intake and discharge vents on the fan were covered in dirt and dust.

On 10/8/15 at approximately11:30 a.m., the Administrator was made aware of the above findings.

No further information was presented prior to exit.
COMPLAINT DEFICIENCY

F 502 SS=D 483.75(j)(1) ADMINISTRATION — F 502

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F 502	Continued From page 146 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain laboratory tests per the physician order for one of 37 residents in the survey sample, Resident #12. The physician ordered a BMP (basic metabolic panel)* on 7/2/15 to be done on "Monday," (7/6/15) and on 7/6/15, the physician ordered a BMP to be done Friday 7-10-15. No results could be found in the clinical record. The findings include: Resident #12 was admitted to the facility on 2/13/12 with diagnoses that included but were not limited to: depression, prostate cancer, atrial fibrillation, osteoarthritis, psychosis, dementia, post traumatic stress disorder, anemia, high blood pressure, dysphagia and chronic obstructive pulmonary disease. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/25/15, coded Resident #12 as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one to two staff members for all of his activities of daily living. The physician order dated, 7/2/15, documented,	F 502	F 502 (D): 1. Resident #12, the Basic Metabolic Panel (BMP) for 7/6/15 was signed and placed in chart. The Responsible Party and the Physician have been made aware that the 7/2/15 and 7/10/15 BMP were not completed. There were no adverse effects for Resident #12. 2. A review of residents with labs ordered in the last 30 days has been completed by the DCS/Designee to ensure that labs have been obtained per the physician's order.	

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"BMP - Monday (7/6/15)."
The physician order dated 7/6/15, documented, "BMP - Friday 7-10-15."

Review of the clinical record did not reveal the results of the tests ordered.

The comprehensive care plan dated, 9/15/14, documented, "Problem: Nutrition/Hydration." The "Approaches & Interventions" documented in part, "Obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated."

The chart was reviewed with LPN (licensed practical nurse) #8 on 10/7/15. A copy of the ordered tests was requested.

At the end of the day meeting on 10/7/15 at 6:14 p.m. a copy of the test results were again requested.

On 10/8/15 at approximately 10:30 a.m. an interview was conducted with LPN #6, regarding the process for obtaining laboratory tests ordered by the physician. LPN #8 stated, "The nurse fills in the lab (laboratory) book. The labs are drawn by the lab company. Once the results come back the physician or nurse practitioner is notified." When asked how staff assures the ordered tests were completed, LPN #8 stated, "The nurse is to follow up in the lab book each day."

An interview was conducted with LPN #11, the unit manager, on 10/8/15 at approximately 10:40 a.m., regarding the process for obtaining laboratory tests ordered by the physician. LPN #11 stated, "The nurse notifies the RP (responsible party) or residents, then fills out a

3. The Staff Development Coordinator/Designee has provided education to currently employed Licensed Staff regarding obtaining labs as ordered by the physician. The DCS/Designee will randomly review the physician's orders for (5) residents weekly for (3) months to ensure labs have been obtained per the physician's order and the results are present on the medical record.
4. Results of the random weekly reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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lab slip in the lab book and then the lab draws them." When asked how the nurse ensures the labs are completed as ordered, LPN #11 stated, "The lab books are read off in morning meeting."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing (DON) on 10/8/15 at 1:41 p.m. When informed of the above concern for the missing laboratory results for Resident #12, the DON stated, "He refused them sometimes but I do know there were one or two we missed in the list you gave us."

The facility policy, "Laboratory Procedure: documented, "Obtain a physician's order for all lab work and write the order on the physician's order sheet. Fill out the necessary lab slips. When the blood is drawn, the nurse or phlebotomist will document in the lab log or in the clinical record. If needed necessary, the facility may keep a special log for laboratory tests being ordered. The results are checked by the Clinical Nurse and the physician is notified of the results. This notification may be written on the Lab Results form. All lab results are kept in a designated place until seen and signed by the physician. The lab results are filled in the patient's chart under the Laboratory section."

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical

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F 502	Continued From page 149 treatment." No further information was provided prior to exit. *The basic metabolic panel (BMP) is a group of blood tests that provides information about your body's metabolism. This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/ency/article/002257.htm>	F 502	F504 (D): 1. Resident #8, a physician's order was obtained for the urinalysis obtained on 8/2/15. The Responsible Party and the Physician were notified of results. 2. Residents currently residing in the facility that require lab services have the potential to be affected. Residents that have had labs including urinalysis obtained in last 30 days will be reviewed by the DCS/Designee to ensure that there was a physician's order for the lab obtained. 3. The Staff Development Coordinator/Designee has provided education to the currently employed Licensed Staff regarding obtaining a physician's order before obtaining a lab including urinalysis. The Assistant Director of Clinical Services/Designee will conduct random weekly reviews for	
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review it was determined that facility staff failed to obtain a physicians order prior to collecting a laboratory (lab) test for one of 37 residents in the survey sample, Resident #8. Facility staff failed to obtain a physician's order prior for collecting a urinalysis dated 8/2/15 for Resident #8. The findings include: Resident #8 was admitted to the facility on 4/4/15 and readmitted on 8/17/15 with diagnoses that included but were not limited to cerebral palsy, oropharygeal dysphagia (difficulty swallowing) with peg tube placement (percutaneous	F 504		

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endoscopic gastrostomy tube placement, or PEG^), osteoarthritis, quadriplegia, neurogenic bladder (uncontrollable bladder due to central nervous system dysfunction) and chronic pain syndrome. Resident #8's most recent MDS (minimum data set) was a quarterly review assessment with an ARD (assessment reference date) of 9/29/15. Resident #8 was coded as being moderately cognitively impaired in the ability to make daily life decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #8 was coded as requiring total dependence on staff with transfers, dressing, eating, toileting, and personal hygiene.

Review of the clinical record revealed a negative U/A C+S (urinalysis with culture and sensitivity) dated 8/2/15. Further review of the clinical record revealed no order for the U/A C+S.

On 10/7/15 at 10:45 a.m., an interview was conducted with LPN (Licensed practical nurse) #6, regarding the process of obtaining a lab. LPN #6 stated, "You would look at the order, write out a lab slip, call lab or collect the lab that should be drawn and then follow up with the MD (Medical doctor)." When asked if a lab can be obtained without an order she stated, "No." LPN #6 stated that the facility had standing orders if nursing felt that a lab should be drawn. When asked if an order should be written for a lab even though it is listed as a standing order she stated, "Yes."

On 10/6/15 at 4 p.m. administration was made aware of the above concerns. No order could be found by administration for Resident #8's urinalysis dated 8/2/15.

Facility policy titled, "Laboratory procedure,"

residents that have had labs obtained to ensure that there were physician's orders obtained and written. This random weekly review will be completed for (5) residents per week for (3) months.

4. The results of the random weekly reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
5. 11/10/2015

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documents the following:

"Obtain a physician's order for all lab work and write the order on the physician's order sheet."

^ This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/presentations/100125_5.htm>

F 514 SS=E — 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE — F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for four of 37 residents in the survey sample, Residents #27, #6, #5 and #19.

1. The facility staff failed to document orders for and administration of insulin (*to treat diabetes) for Resident #27 on 10/4/15.

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2. The facility staff failed to accurately document a treatment for a pressure ulcer for Resident #6 on 10/7/15.

3. The facility staff failed to ensure a face sheet for another resident was not filed on Resident #5's medical record.

4. The clinical note written by the nurse practitioner following a visit with Resident #19 was not filed in Resident #19's clinical record.

The findings include:

1. The facility staff failed to document orders for and administration of insulin (*to treat diabetes) for Resident #27 on 10/4/15.

Resident #27 was admitted to the facility on 6/9/15 and readmitted on 9/19/15 with diagnoses including, but not limited to: quadriplegia, pressure ulcers, contractures and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 9/16/15, he was coded as being moderately cognitively impaired for making daily decisions. He was coded as having received insulin injections for all seven days of the look back period.

A review of the orders for Resident #27 revealed, in part, the following: "Check blood sugar four times daily. Call MD if <60 or >400 (less than 60 or greater than 400). Novolog flex pen (*short-acting insulin) inject 4 units subcutaneously (under the skin) three times a day before meals - hold for blood sugar less than

F514 (D):

1. Resident #27 has a telephone order for the insulin given on 10/4/15. For Resident #6, the physician and the responsible party were both notified. There was no adverse effect for Resident #6. Resident #6 no longer resides in the facility. Resident #5 has an accurate face sheet in the medical record and the inaccurate face sheet was removed from Resident #5 medical record. Resident #19 now has the clinical note in the medical record from the Nurse Practitioner's visit.

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200." This was written and signed on 8/27/15 by the nurse practitioner. Further review of the provider's orders for Resident #27 failed to reveal any other orders for short-acting insulin administration for Resident #27 on 10/4/15. Further review failed to reveal administration of any insulin other than the above-referenced order on 10/4/15.

A review of the clinical record for Resident #27 revealed an SBAR (situation/background/appearance/review and notify) communication form completed by LPN (licensed practical nurse) #16 on 10/4/15. Review of the narrative portion of the form revealed, in part, the following: "BS (blood sugar) was 585 at 4p (4:00 p.m.). Gave the 4 units before dinner. Per [name of nurse practitioner] give 2u (two units) more. Check in an hour. Checked @ (at) 5:30. BS 511. [Name of nurse practitioner] advised to give 12 units more, recheck 1 hour. 9p (9:00 p.m.) BS 310. Checked blood sugar again at 11 p (11:00 p.m.). 555 (blood glucose = 555). Called [name of nurse practitioner on call]. Advised to give 15 units." The narrative portion of the SBAR ended there.

Further review of the provider's orders for Resident #27 failed to reveal documentation of the above-referenced orders for short-acting insulin administration for Resident #27 (two units at 4:00 p.m., 12 units at 5:30 p.m., and 15 units at 11:00 p.m. on 10/4/15). Further review of the MAR (medication administration record) failed to reveal administration of any insulin other than the four units before dinner on 10/4/15.

A review of the comprehensive care plan for Resident #27 dated 6/19/15 revealed, in part, the

F 514

2. Residents currently residing in the facility have the potential to be affected. Residents that require insulin will be reviewed by the DCS/Designee to ensure that telephone orders are present and transcribed on Medication Administration Record. For residents currently residing in the center, medical records will be reviewed to ensure that face sheets are present on the medical record and that there are not face sheets for other residents inappropriately filed in the medical record. Resident medical records will be reviewed to ensure that progress notes for Physician/Nurse Practitioner/Provider visits are filed on the medical record after the visit. Residents residing in the

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following: "Monitor for S/S (signs/symptoms) of hypo or hyperglycemia (low or high blood sugar) including changes in LOC (level of consciousness), sleepiness, fatigue/weakness. . .Blood glucose levels as ordered."

On 10/8/15 at 9:05 a.m., LPN #16 was interviewed regarding the above-referenced note and administration of 15 units of insulin to Resident #27. She stated that Resident #27 had recently been started on tube feedings and that his blood sugars "had been running high that day." She stated: "I know I did not document the orders or the insulin. I did not fill out a verbal order paper or put it on the MAR. To be honest, I was so concerned with treating his high blood sugar, writing things down was not a priority. I know I should have. But I didn't." When asked which type of insulin she administered at 4:00 p.m., 5:30 p.m., and 11:00 p.m. on 10/4/15, LPN #16 stated: "Short acting."

On 10/8/15 at 9:35 a.m., ASM (administrative staff member) #4, the nurse practitioner, was interviewed regarding the above concerns. She stated that she was aware that Resident #27's blood sugars had been elevated on 10/4/15 due to the initiation of tube feedings. She stated she remembered being called by LPN #16 on the night of 10/4/15, and that she remembered giving several orders for extra short-acting insulin. She stated: "When I give extra short-acting insulin, my order is always to check it again in an hour and to call me if it is above 350."

On 10/8/15 at 10:00 a.m., ASM (administrative staff member) #1, the administrator, LPN #8, the unit manager, and ASM #3, the corporate nurse, were interviewed regarding these concerns. ASM

center with pressure ulcers will have their Physician's Orders and Treatment Administration Record reviewed by the DCS/Designee to ensure that the treatment has been appropriately documented on the Treatment Administration Record per the physician's order.

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#1 stated: "We are aware that these orders are not recorded and that there is nothing on the MAR for them. This resident required a lot of time from this nurse. It was an oversight." When asked if the orders should have been recorded and the insulin administration documented on the MAR, ASM #1 stated, "Yes, it absolutely should have been documented."

On 10/8/15 at 2:50 p.m., RN (registered nurse) #4 was interviewed regarding transcribing verbal orders. She stated that when she receives a verbal order from a provider, she transcribes it onto a verbal order sheet, faxes it to the pharmacy and puts the order on the MAR so that it can be signed off by whomever follows the order.

On 10/8/15 at 3:00 p.m., LPN #19 was interviewed regarding assessment after administering an extra dose of short-acting insulin. She stated that she usually rechecks the blood sugar in 30 minutes just to make sure the levels are acceptable. She stated that at 30 minutes, the insulin's action should have peaked. She stated that she documents the blood sugar level and puts it on the 24 hour report so that subsequent shift nurses can see what has happened.

On 10/8/15 at 2:50 p.m., ASM (administrative staff member) #1 and ASM #2, the director of nursing, were informed of these concerns. Policies regarding a complete and accurate clinical record were requested.

A review of the facility policy entitled "Clinical/Medical Records" revealed, in part, the following: "Clinical Records are maintained in

3. The Staff Development Coordinator/Designee has provided education to Licensed Staff as well as the Medical Records personnel regarding obtaining, writing, and transcribing insulin orders, ensuring that the face sheet is present in the clinical record for the appropriate resident, ensuring that clinical progress notes are filed in the medical record timely after Physician/Nurse Practitioner visits, and ensuring that treatment is appropriately documented for residents with pressure ulcers. Random weekly reviews will be conducted by the DCS/Designee for (5) residents per week for (3) months to ensure that residents requiring insulin have orders written and transcribed to the MAR and that treatment is documented appropriately for residents with pressure ulcers.

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F 514	Continued From page 156 accordance with professional practice standards to provide complete and accurate information on each resident for the continuity of care. . .The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care." No further information was provided prior to exit. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team." 2. The facility staff failed to accurately document a treatment for a pressure ulcer for Resident #6 on 10/7/15. Resident #6 was admitted to the facility on 11/21/14 and most recently readmitted on 12/10/14 with diagnoses including, but not limited to: arthritis, heart disease, chronic pain, major depressive disorder, diabetes and systolic heart failure. On the most recent MDS (minimum data set), a significant change assessment dated 6/26/15, Resident #6 was coded as having no	F 514	Random Weekly reviews will be conducted by Medical Records Personnel/Designee for (5) residents per week for (3) months to ensure face sheets are present in the clinical record for the appropriate resident and that clinical progress notes are filed in the medical record after Physician/Nurse Practitioner visits. 4. Results of the random weekly reviews will be discussed by the Administrator/Designee(s) at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance. 5. 11/10/2015	

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cognitive impairment for making daily decisions. She was coded as having a stage three pressure ulcer**. She was coded as requiring the extensive assistance of staff for bed mobility, dressing, toileting, personal hygiene and bathing.

On 10/7/15 at 9:20 a.m., Resident #6's wound care was observed, with her permission. LPN (licensed practical nurse) #7 provided the wound care. Prior to going into the room, LPN #7 prepared the treatment to be applied to Resident #6's pressure ulcer. She squeezed three mls (milliliters) of Silvadene^ ointment into a medicine cup. Once she had removed the old dressing and cleansed Resident #6's stage three pressure ulcer on her lower middle sacrum, she applied the Silvadene cream to the wound using a sterile cotton applicator. The wound measured 1.3 cms (centimeters) by 1.2 cms by 0.7 cms. It was unchanged in measurements since 10/5/15. She completed the wound care by applying a sterile dressing.

A review of the physician's orders for Resident #6 revealed the following order, written on 8/10/15 by LPN #7 and signed by the provider on 9/11/15: "D/C Silvadene to lower medical sacrum. Cleanse wound to lower medial sacrum with wound cleanser. Apply Calcium Alginate AG^^, cover, and secure QD (daily) and prn (as needed)."

A review of the treatment administration record (TAR) for Resident #6 for October 2015 revealed the following entry: "Cleanse wound to lower medial sacrum with wound cleanser. Apply Calcium Alginate AG^^, cover, and secure QD (daily) and prn (as needed)." In the square designated for 10/7/15, LPN #7 had placed her

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initials.

A review of the comprehensive care plan for Resident #6 dated 4/1/14 and updated 7/10/15 revealed, in part, the following: "Skin/Wound. Administer medications as ordered."

On 10/7/15 at 2:25 p.m., LPN #7 was asked if she remembered what treatment she had applied earlier in the day to Resident #6's wound. She stated: "I put Silvadene on it." When asked if she knew what treatment was indicated on the most recent signed provider's order and TAR, she stated: "Silvadene. That's what I have written on my paper." LPN #7 accompanied the surveyor to look at the current order for Resident #6's pressure ulcer treatment. LPN #7 stated: "Oh no. It says Calcium Alginate. But I know it's supposed to be Silvadene. [The wound doctor's] most recent progress note says Silvadene. I just need to change the TAR and write a new order for the Silvadene."

On 10/8/15 at 9:00 a.m., ASM (administrative staff member) #5, the consulting wound doctor, was interviewed regarding these concerns. When asked what treatment he intended for Resident #6 to be getting on the stage three pressure ulcer, he stated: "I had changed her treatment from Silvadene to Calcium Alginate." He stated, however, that he had neglected to make this change in his progress notes. He stated: "That was my error." He stated that he had given a new order earlier that morning (10/8/15) to change the order back to Silvadene "because the resident is non-compliant." He stated: "It's okay for her to get the Silvadene now."

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On 10/8/15 at 9:40 a.m., LPN #7 approached the surveyor and showed her the new order given by the wound doctor earlier in the morning. The order was for Silvadene to be applied to the pressure ulcer daily. When asked how she knows what treatments to apply to a resident's pressure ulcer, she stated: "I usually go by what's written on my paper. I get that from the doctor's notes. I understand he wanted the Calcium Alginate. I should have been going off his order yesterday, rather than his note, I guess."

On 10/8/15 at 2:50 p.m., ASM (administrative staff member) #1 and ASM #2, the director of nursing, were informed of these concerns. Policies regarding following orders for administering medications as ordered were requested.

No further information was provided prior to exit.

*The NPUAP defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.

**Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. http://www.npuap.org/resources/educational-and-

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clinical-resources/npuap-pressure-ulcer-stagescategories/

^Silver sulfadiazine (Silvadene), a sulfa drug, is used to prevent and treat infections of second- and third-degree burns. It kills a wide variety of bacteria. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682598.html.

^^Calcium alginate dressings have been used in the treatment of pressure ulcers and leg ulcers. http://www.ncbi.nlm.nih.gov/pubmed/1831374.

In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

3. The facility staff failed to ensure a face sheet for another resident was not filed on Resident #5's medical record.

Resident #5 was admitted 5/13/14 with the diagnoses of but not limited to multiple sclerosis, encephalopathy, depression, bipolar, anxiety and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/8/15. The resident was coded as being mildly cognitively impaired in ability to make daily life decisions, scoring an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for

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bathing; extensive assistance for dressing and hygiene; limited assistance for transfers; supervision for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed a face sheet for another resident, in the front of the chart, which included but not limited to that resident's name, date of birth, diagnoses, insurance information, physician information, and family contact information.

On 10/7/15 at 4:45 p.m., in an interview with LPN #10 (Licensed Practical Nurse #10) she stated the face sheet should not be on that record.

On 10/7/15 at 5:30 p.m., the Administrator and DON (Director of Nursing) was made aware of the findings. No further information was provided by the end of the survey.

4. The clinical note written by the nurse practitioner following a visit with Resident #19 was not filed in Resident #19's clinical record. Resident #19 was admitted to the facility on 4/30/15 with a readmission on 6/18/15, with diagnoses that included, but were not limited to: epilepsy (a form of seizures), anxiety, hypertension, depression, pain and ulcer. The most recent MDS (minimum data set) assessment, was a quarterly assessment with an ARD (assessment reference date) of 9/8/15. Resident # 19 was coded as scoring two out of a possible 15 on the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns, indicating the resident was severely cognitively impaired.

A review of Resident #19's clinical record

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revealed that a dictated note from a clinical visit that occurred on 8/10/15 was not filed in the clinical record.

An interview was conducted with ASM (administrative staff member) #4, the nurse practitioner, on 10/8/15 at 9:30 a.m. ASM #4 revealed that she had seen Resident #19 on 8/10/15 and had dictated a note to that effect. ASM #4 was asked where the note was filed; ASM #4 stated that it sometimes it took upwards of a month to get the note into the clinical record. When asked why it took so long to get her notes placed in the clinical record ASM #4 responded, "The practice tries three times to fax the document and if it doesn't go through it gets put aside until we either call and request it or they remember to retry again."

On 10/8/15 at 3:15 p.m. an interview was conducted with OSM (other staff member) #17, the medical records director. OSM #17 was asked where the physician /nurse practitioner notes are faxed. OSM #17 responded, "They are faxed to me within one to two weeks." OSM #17 was asked how she knew if something was missing from a record, OSM #17 responded, "I keep a spreadsheet on the computer which lets me know which notes are still needed. I check them off as they come in." OSM #17 was asked if she was aware that a dictated note dated 8/10/15 was not in Resident #16's clinical record. OSM #17 stated that she was not aware, "I usually call the hospital to get them, and I don't know how this was missed."

A review of the facility policy titled "Clinical / Medical Records" revealed, in part, the following documentation: "Policy: The clinical record shall

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contain information to identify the resident clearly; a record of the resident's assessments; the plan of care and services. Current medical records shall be completed promptly."

On 10/8/15 at 3:30 p.m. ASM (administrative staff member) #1, the administrator, was made aware of these findings. No further information was provided prior to the end of the survey.